Louisiana

Recredentialing Checklist for Facilities

All required documents must be fully completed with a handwritten signature and date (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

Please return completed Health Delivery Organization Reverification Form and all required documents to Blue Cross by the date on your recredentialing notification letter. See Facility Providers Credentialing Criteria for more information.

- ☐ Complete the Health Delivery Organization (HDO) Reverification Form
  - ☐ Complete the Health Delivery Organization Statement of Attestation
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*)
- ☐ Enclose this completed checklist
- ☐ Complete the applicable HDO Attachment
  - ☐ HDO Attachment A: Ambulance Company
  - ☐ HDO Attachment B: DME Supplier or Pharmacy
  - ☐ HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility
  - ☐ HDO Attachment D: Urgent Care Clinic / Walk-in Clinic
  - ☐ HDO Attachment E: Diagnostic Radiology (Free-standing)
  - ☐ HDO Attachment F: Retail Health
  - ☐ HDO Attachment G: Laboratory
  - ☐ HDO Attachment H: Outpatient Cath Lab

Submit all required documents using one of the options below:

mail: BCBSLA - Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

email: network.administration@bcbsla.com
fax: (225) 297-2750
Attention: Network Operations

If you have any questions about our credentialing requirements, please visit our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks.

18NW2522 04/18

Louisiana

Health Delivery Organization Reverification Form

FIRST PRACTICE LOCATION

Name of Facility							
Physical Address							
City				State		ZIP Code	
Parish/County				Physical Address Email			
Main Phone Number	Appointment Phone Number			Fax Number		Tax Identification Number	
Facility Contact				NPI Number			
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Billing Address *(where you want payments sent)*							
City				State		ZIP Code	
Billing Address Email	Phone Number			Fax Number		Billing Contact Person	
Correspondence Address *(where you want communications sent)*							
City				State		ZIP Code	
Correspondence Address Email	Phone Number			Fax Number		Correspondence Contact Person	
Medical Records Address *(where you want medical record requests sent)*							
City				State		ZIP Code	
Medical Records Email	Phone Number			Fax Number		Medical Records Contact Person	

Does the office offer handicapped access for:	Building ☐ Yes ☐ No	Parking ☐ Yes ☐ No	Restroom ☐ Yes ☐ No	Other
Accessible by public transportation:	Bus ☐ Yes ☐ No	Courier Service ☐ Yes ☐ No	Other	

Offers services for the disabled:	Text Telephony (TTY) ☐ Yes ☐ No	American Sign Language ☐ Yes ☐ No	Mental/Physical Impairment Services ☐ Yes ☐ No	Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements?
☐ Yes ☐ No

Patient Ages: Please check the age ranges of the client populations you treat

☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages

☐ Other (please specify):

18NW2515 03/18

SECOND PRACTICE LOCATION

If more than two locations, please attach a separate listing.

Name of Facility			
Physical Address			
City		State	ZIP Code
Parish/County		Physical Address Email	
Main Phone Number	Appointment Phone Number	Fax Number	Tax Identification Number
Facility Contact			NPI Number

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Billing Address *(where you want payments sent)*

City		State	ZIP Code
Billing Address Email	Phone Number	Fax Number	Billing Contact Person

Correspondence Address *(where you want communications sent)*

City		State	ZIP Code
Correspondence Address Email	Phone Number	Fax Number	Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City		State	ZIP Code
Medical Records Email	Phone Number	Fax Number	Medical Records Contact Person

Does the office offer handicapped access for:	Building ☐ Yes ☐ No	Parking ☐ Yes ☐ No	Restroom ☐ Yes ☐ No	Other
Accessible by public transportation:	Bus ☐ Yes ☐ No	Courier Service ☐ Yes ☐ No	Other	

Offers services for the disabled:	Text Telephony (TTY) ☐ Yes ☐ No	American Sign Language ☐ Yes ☐ No	Mental/Physical Impairment Services ☐ Yes ☐ No	Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements?
☐ Yes ☐ No

Patient Ages: Please check the age ranges of the client populations you treat

☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages

☐ Other (please specify):

ORGANIZATION SPECIALTY

- ☐ Alcohol/Drug Rehabilitation Center (CDU)
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ Infusion Therapy Provider
  - ☐ Suite
  - ☐ Home
- ☐ Outpatient Cardiac Catheterization Facility
- ☐ Radiation Center (Free Standing)
- ☐ Rural Health Clinic
  - ☐ FQHC
  - ☐ RHC
- ☐ Other
- ☐ Ambulance Services
- ☐ DME
- ☐ Intensive Outpatient Program
- ☐ Partial Hospitalization Program
- ☐ Rehabilitation Center (Physical) (Free Standing)
- ☐ Sleep Disorder Clinic/Lab
- ☐ Ambulatory Surgery Center
- ☐ Home Health Agency
- ☐ Laboratory
- ☐ Psychiatric Hospitals
- ☐ Renal Dialysis Center
- ☐ Skilled Nursing Facility (Free Standing)
- ☐ CDU (Free Standing)
- ☐ Hospice
- ☐ Lithotripter Facility
- ☐ Psychiatric Hospital (Free Standing)
- ☐ Residential Treatment Center
- ☐ State Owned Psychiatric Hospital
- ☐ Charity – Acute Care Hospital
- ☐ Hospital
- ☐ Long Term Acute Care Facility
- ☐ Radiology (Diagnostic)
  - ☐ Diagnostic Imaging
  - ☐ PETS
- ☐ Retail Health Clinic
- ☐ Urgent Care Clinic/Walk-In Clinic

GENERAL BUSINESS INFORMATION

Beginning Date of Operation	Ownership Name

Type of Ownership:

☐ Individual ☐ Partnership ☐ Corporation ☐ Other (please specify)

Administrator Name	Phone Number

Website Address (if applicable)

ACCREDITATION INFORMATION

Is your organization approved by a national accrediting body? ☐ Yes ☐ No *If yes, please list your accrediting body and submit a copy of your accreditation letter or certificate.*	Expiration Date
Were there any deficiencies from your last survey? ☐ Yes ☐ No *If yes, please attach an explanation and your action plan to address deficiencies.*	Effective Date
Have deficiencies been removed? ☐ Yes ☐ No	Effective Date

LICENSE INFORMATION

State License Number

Please indicate one or more of the following and submit a copy of license:

- ☐ State DHH License
- ☐ Occupational License
- ☐ CLIA Certificate
- ☐ Operational License
- ☐ DHH Permit to Operate – Medical Gases (DME providers when applicable)

Were there any deficiencies from your last survey?

☐ Yes ☐ No

If yes, please attach an explanation and your action plan to address deficiencies.

Have deficiencies been removed? ☐ Yes ☐ No	Effective Date

MEDICARE INFORMATION

Do you participate in Medicare?

☐ Yes ☐ No

If yes, please complete the following and submit a copy of participation letter:

Medicare Number: Effective Date of Participation:

Were there any deficiencies from your last survey? ☐ Yes ☐ No *If yes, please attach an explanation and your action plan to address deficiencies.*	Effective Date
Have deficiencies been removed? ☐ Yes ☐ No	Effective Date
Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified? ☐ Yes ☐ No *If yes, please attach an explanation and your action plan to address suspension/sanctions.*	Effective Date
Is suspension still active? ☐ Yes ☐ No	Effective Date

Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?

☐ Yes ☐ No

If yes, please attach an explanation and your action plan to address suspension/sanctions.

Have sanctions been removed? ☐ Yes ☐ No	Effective Date

GENERAL QUESTIONS – FOR FEDERALLY QUALIFIED RURAL HEALTH CLINICS ONLY

Do you have a physician onsite during <u>all</u> hours of operation?

☐ Yes ☐ No

If yes, provide physician's full name and specialty:	If no, please explain:
Do you offer appointments? ☐ Yes ☐ No	Do you provide urgent and minor emergency care to patients on an unscheduled basis? ☐ Yes ☐ No

Are patients referred to their primary physician for routine follow-up and wellness care?

☐ Yes ☐ No

PROFESSIONAL OR PRODUCTS LIABILITY INSURANCE COVERAGE INFORMATION

DME providers only will need to submit Products Liability Insurance Coverage Information.

Name of Carrier	Policy Number
Effective Date	Expiration Date

Amounts Per Incident/Aggregate for Professional or Products Liability Coverage

Has your current insurance carrier excluded any products or procedure from your insurance coverage policy?

☐ Yes ☐ No *If yes, attach an explanation.*

Do you participate in the Louisiana Patients' Compensation Fund?

☐ Yes ☐ No

Please submit a copy of the current Certificate of Insurance and LPCF Certificate, as applicable. All insurance certificates must include the name and address of the requesting facility, not the ownership corporation.

STATEMENT TO APPLICANTS

All organizations applying for network participation have the right to review information obtained by Blue Cross and Blue Shield of Louisiana to evaluate their credentialing application. The only exception to this policy is information that we are prohibited by law from releasing.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have 10 days to submit additional information to correct the discrepancy or provide clarification that may positively impact the credentialing decision.

PLEASE SUBMIT COPIES OF THE FOLLOWING DOCUMENTS WITH THIS APPLICATION IF APPLICABLE TO YOUR PROVIDER TYPE

- Accrediting entity certification (JCAHO, CHAP, etc.)
- License (State, Occupational, CLIA, etc.)
- Medicare Participation Letter (if applicable)
- Professional Liability Insurance Certificate or Products Liability Insurance Certificate (DME Providers)
- Louisiana Patients' Compensation Fund Certificate (if applicable)
- If your organization is an Ambulance company, please complete attachment A
- If your organization is a DME supplier, please complete attachment B
- If your organization is a Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility, please complete attachment C
- If your organization is an Urgent Care/Walk-In Clinic, please complete attachment D
- If your organization is a Free Standing Diagnostic Radiology Center, please complete attachment E
- If your organization is a Retail Health Clinic, please complete attachment F
- If your organization is a Laboratory (free-standing), please complete attachment G
- If your organization is an Outpatient Cath Lab with Accreditation, please complete attachment H
- EIN Letter and W-9
- EFT, iLinkBlue and Business Associate Agreement
- Health Plan Agreement (if applicable)

Return application and documents to:

Email: network.administration@bcbsla.com Fax: (225) 297-2750

Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

HEALTH DELIVERY ORGANIZATION STATEMENT OF ATTESTATION

I hereby affirm that the information furnished by me is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatements in, or omissions from, this application, whether intentional or not, shall constitute cause for summary dismissal as a Blue Cross and Blue Shield of Louisiana (BCBSLA) provider. In the event that participation privileges have been granted prior to such misstatement or omission, such discovery may result in termination from BCBSLA.

I agree that I have a continuing affirmative duty to inform BCBSLA immediately of any material changes that may affect my organization's status. I consent to the release of all information that may be relevant to an evaluation of my organization's credentials, including information about disciplinary actions or other confidential or privileged information, to BCBSLA or its affiliates or successors. I understand and agree that this consent is irrevocable for any **period during which** my organization participates as a BCBSLA provider. I release BCBSLA, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my organization's credentials.

I submit this application in the expectation that confidentiality and privacy will be preserved, and that the information will be used only for credentialing, peer review, and quality assurance activities.

Facility Name	
Signature of Authorized Representative	Date
Print Name	Title

Date may not be more than 180 days old at the time of the Credentialing Committee approval.

Signature and date must be original. Signature stamps or date stamps are not acceptable.