LOUISIANA PATIENT'S COMPENSATION FUND
SELF INSURED HEALTHCARE PROFESSIONAL RENEWAL APPLICATION

PCF6R
10/26/2015
10:17:49

DATES OF ENROLLMENT APPLYING FOR: _____ **TO:** _____
Enrollment Dates - Required

I, _____ , _____
PRINT First Name, Middle Name and Last Name - Required (Professioinal Degree)

am licensed to provide professional medical services as a _____
Professional Specialty - Required

Office Name & Address (no P.O. Box):

_____
Office Name & Physical/Street Address - Required

_____
Office Physical/Street Address Line 2

_____ **Telephone:** _____
Office Name & Physical/Street Address City, State and Zip Code - Required

LICENSE #: _____ **Date of Birth:** _____
License Number - Required Date of Birth - Required

Email: _____

Do you work less than 20 hours per week? ____ **No** **Yes** ____ **If so, complete PCF12**

****Advanced Practice Nurse -- list supervising physician:** _____

I further certify that the appropriate security (proof of financial responsibility) is in place and current at the following institution:

_____ in the name of _____

Circle any that apply to your practice:

☐ Spa Services	☐ Laser Hair Removal	☐ Botox
☐ Facial Fillers	☐ Facial Chemical Peels	☐ Tatoo Removals

INCLUSIONS: Employed Allied Healthcare Providers.
EXCLUSIONS: This does not include those who require a PCF surcharge, such as, NP's, PA's, CNS', CRNA's, etc.

PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

(1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.
(2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.
(3) Services or treatment rendered as a licensed provider in states other than Louisiana, even if the underlying insurer provides coverage for same.

Your attention is directed to LAC 37:III, Chapter 11, §§1101-1105, which sets forth the cost and reserve reporting requirements which you must satisfy within the time allotted therein. Please note §1105 which provides for the cancellation and termination of enrollment with the Patient's Compensation Fund for failure to comply with these reporting requirements.

I hereby certify that there have been no changes in any aspect addressed by this form since my last completed application to the LA PCF especially in regards to questions number 10, 11 and 12.

My self insured coverage is through _____

10/26/2015

Date **Printed Name of Insured** Signature of Insured -- **NOT VALID WITHOUT SIGNATURE**

Any questions regarding this form may be emailed to: pcf-surcharge@la.gov
A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.

Save & Print