LOUISIANA PATIENT'S COMPENSATION FUND SELF-INSURED GROUP APPLICATION

(FOR FTE's, Locum Tenens, Clinics, ER Groups, Surgical Centers, etc.)

PCF16
09/14/2023
16:01:50

1: PROVIDER DETAILS

*****Complete Name & Mailing Address**

Complete Name - Required

Street/Mailing Address Line 1 - Required

Street/Mailing Address Line 2

City, State Zip Code - Required

LICENSE #: _____

License Number - Required

Professional Specialty: _____

Professional Specialty - Required

PCF Code: _____

Phone #: _____ **EMAIL:** _____

2: DATES OF ENROLLMENT APPLYING FOR: _____ To: _____

Effective Date - Required Expiration Date - Required

TYPE OF FTE'S	NUMBER OF FTE'S

NUMBER OF OUTPATIENT VISITS/DRAWS/PROCEDURES: _____

HOSPITALS YOU SERVICE: _____

Must advise the PCF of any offsite entities or multiple locations for which coverage is provided along with the address for each location and proof of financial responsibility.

INCLUSIONS: *Employed allied healthcare providers.*

EXCLUSIONS: *This does not include those who require a PCF surcharge,- MD's, NP's, PA's, CNS', CRNA's, etc. These must be listed or included in the FTEs and the appropriate surcharge paid.*

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.

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

_____

in the name of: _____

09/14/2023

Date **Signature -- 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.

Revised: 07/01/2014