

**LOUISIANA PATIENT'S COMPENSATION FUND
HOSPITAL & NURSING HOME APPLICATION
(RENEWAL FOR THOSE WITH PRIMARY INSURANCE)**

1: PROVIDER DETAILS

****Complete Name & Mailing Address:

LICENSE #:

Professional Specialty:

PCF Code:

2: PRIMARY COVERAGE – The COI or declarations page from the insurer’s policy is REQUIRED.

Insuring Company:

Policy #:

Effective Dates: _____ to _____

Retro Date (if applicable)***:

Primary Premium:

PCF Surcharge:

Professional Liability Limits:

Each Claim/

Aggregate

HOSPITAL & NURSING HOME Average Daily Census (if applicable):

| HOSPITAL | | NURSING HOME/ASSISTED LIVING FACILITY | |
|---------------------------------|--|---------------------------------------|--|
| Acute | | Skilled/Intermediate | |
| Skilled / LTAC | | | |
| Rehab | | | |
| Psych / Dependency | | | |
| Outpatient Visits | | Assisted Living (only if | |
| Ambulance/EMS (see rate manual) | | licensed as assisted living) | |
| Pharmacists (see rate manual) | | | |
| ER staffed by: | | | |

****IF COVERAGE IS IN PLACE FOR A CORPORATION, PLEASE PROVIDE A SEPARATE CERTIFICATE OF INSURANCE AND A CORPORATION APPLICATION (PCF9), WHICH CAN BE FOUND ON OUR WEBSITE

www.doa.la.gov/Pages/pcf/Index.aspx

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 underlying coverage.

EMPLOYEES AS ADDITIONAL INSURED: Please see below inclusions/exclusions; complete the proper form and include proof of underlying coverage.

NOTE:

Failure to comply with cost and reserve reporting requirements set forth in LAC 37:III, §§1101-1105 could result in termination of PCF coverage.

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.

DATE _____

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.