PCF QUESTIONNAIRE FOR PART-TIME PROVIDERS AND/OR ADMINISTRATIVE MEDICINE PROVIDERS

Provider Name _____ Specialty _____
Complete Name - Required — Professional Specialty - Required

Coverage period: _____ to _____ Part Time Effective Date: _____
Effective Date - Required — Expiration Date - Required

Underlying Insurer : _____ OR: ☐ Self-Insured

(This questionnaire applies only to the enrollment you are requesting a part time discount on)

At this time the Louisiana Patients' Compensation Fund offers discounts on the surcharge for health care providers who are not working full time. There are specific hour limits for the different levels of discount. Since you are currently requesting or receiving a discount, we ask that you provide specific information about your hours of work to verify that you qualify for the discount. **Please note that actual time spent with a patient is not the only part of patient care. If you are in the office you are not only seeing your patients but you are also noting the patient charts, reading patient x-rays, answering telephone calls in regards to the patient, etc.**

Providers who work up to 35 hours per month (i.e. about 8 hours per week) may request a 75% discount. Providers who work up to 65 hours per month (i.e. about 15 hours per week) may request a 50% discount. Providers who work up to 85 hours per month (i.e. about 19 hours per week) may request a 25% discount.

My current practice involves (check all that apply):

	direct patient care, chart review, patient calls, review of x-rays, review of lab results, etc.	
	surgery and/or invasive procedures	
	supervision of students, residents or fellows	
	supervision of Physician's Assistants, Nurse Practitioners or other provider extenders	
	peer review, utilization review, medical direction or other exercise of professional judgment which does not involve direct patient contact	
	dispensing of medications or medical equipment	
	other:	

My current practice sites include (check all that apply)

	office or clinic where patients are seen (including school based clinics)	
	hospital, nursing home or other inpatient facility	
	surgical center, therapy or treatment center, birthing center or other outpatient facility	
	mobile patient care such as emergency medical services or on-site programs	
	professional school where patients receive care - part of a university system	
	professional school where patients receive care - not affiliated with a university	
	federal government site that is covered by the Federal Tort Claims Act (VA, FQHC, etc)	
	Community Health Care Clinic that renders gratuitous medical or dental treatment	
	administrative offices where patients are not seen for professional services	
	other:	

If you work in multiple locations, please provide the name, location, job title and work schedule for each practice situation/location.

Please describe your current professional employment (all that apply)

☐ I currently work a regular schedule of approximately _____ **hours per week,** _____ **weeks per year.**

☐ I currently work on an as needed basis approximately _____ **hours per week,** _____ **weeks per year.**

☐ I currently work temporary positions approximately _____ **hours per week,** _____ **weeks per year.**

☐ I currently have work related coverage, but I wish to maintain personal professional liability coverage.

☐ I am not currently working in patient care in Louisiana, but I wish to maintain professional liability coverage.

Based on the schedule described above, and the PCF rate manual allowances for part-time discounts, I am requesting a discount of **25% 50% 75%** (circle one) off my PCF surcharge. By signing this statement, I am certifying that I am requesting coverage for the hours stated above and that my practice time does not exceed the allowable hours for this discount.

07/21/2015

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

After form has been completed, printed and signed, please mail or fax to:

LOUISIANA PATIENT'S COMPENSATION FUND
P. O. BOX 3718
BATON ROUGE, LA 70821
FAX: (225) 342-5593

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.

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