LOUISIANA PATIENT'S COMPENSATION FUND

CREDENTIALING REQUEST FORM

REQUESTED BY: _____

FAX / EMAIL: _____

RE: PROVIDER'S FULL NAME: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

ADDRESS CITY, STATE ZIP CODE: _____

CERTIFICATES OF ENROLLMENT can be obtained from the PCF website for current enrollment.

ALL REQUESTS FOR CLAIM DATA IS CONSIDERED PERSONAL AND CONFIDENTIAL AND CANNOT BE RELEASED WITHOUT SIGNED AUTHORIZATION FROM THE HEALTH CARE PROVIDER. THE SIGNED AUTHORIZATION MUST BE ATTACHED PRIOR TO RELEASE OF INFORMATION. In accordance with Act 306 of the 2004 Regular Session, the filing of a request for a medical review panel is not reportable. Therefore, this agency will only report claims known to have a suit or other documents filed in court or for which this agency has made a payment. See LA R.S. 40:1299.47.A.(1)(a).

LIABILITY PROVIDED: EXCESS TO $100,000 PRIMARY COVERAGE UP TO $400,000 PLUS UNLIMITED RELATED MEDICAL EXPENSES PER La RS 40:1299.42
There is no aggregate with the PCF

BOTTOM PORTION TO BE COMPLETED BY PCF

TYPE OF POLICY/ENROLLLMENT: ☐ **CLAIMS MADE** ☐ **OCCURRENCE**

PROVIDER SPECIALTY/CLASS: _____

PCF rate manual dictates class and procedures applicable to class/specialty above

PCF COVERAGE PERIOD: FROM _____ **TO** _____

PAID CLAIMS DETAILS and CLAIMS HISTORY: ☐ **None** ☐ **SEE ATTACHMENT**

COMPLETED BY: _____ _____

SIGNATURE DATE

LOUISIANA PATIENTS' COMPENSATION FUND
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FAX (225) 342-5593
Website: lapcf.info