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

Provider Name | Specialty

Coverage period: to | Part Time Effective Date:

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):

My current practice sites include (check all that apply)

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)

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.

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.