LOUISIANA PATIENT'S COMPENSATION FUND GROUP APPLICATION

(RENEWAL FOR FTE's, Locum Tenens, Clinics, ER Groups, Surgical Centers with PRIMARY INSURANCE)

PCF5R
01/30/2024
08:36:05

1. PROVIDER DETAILS

***Complete Name & Mailing Address**

Complete Name - Required

Street Address Line 1 - Required

Street Address Line 2

City, State Zip Code - Required

LICENSE #: License Number - Required

Professional Specialty: Professional Specialty - Required

PCF Code:

Phone #:

EMAIL:

2. PRIMARY COVERAGE -- The COI or declarations page from the insurer's policy is REQUIRED.

Insuring Company: Insuring Company - Required Field

Policy #:

Effective From: Effective Date - Required

To: Expiration Date - Required

Retro Date (if applicable)*:**

Policy Form: ____ **Claims Made*** or Occurrence** ____

Policy Form Selection - Required

Primary Premium:

PCF Surcharge:

Professional Liability Limits:

Each Claim/

Aggregate

If Locum Tenens, what physician are you covering for:

Hospitals you service:

NUMBER OF OUTPATIENT VISITS/DRAWS/PROCEDURES:

TYPE OF FTE'S	NUMBER OF FTE'S	NUMBER OF HOURS -- PER WEEK

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 INSUREDS: Please see below inclusions/exclusions; complete the proper form and include proof of underlying 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.

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.*

01/30/2024

Date **Printed Name of Insured** **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.

Save & Print