LOUISIANA PATIENT'S COMPENSATION FUND
MANAGEMENT COMPANY APPLICATION
(for those with underlying self-insurance or primary coverage)

NAME AND PHYSICAL ADDRESS OF MANAGEMENT COMPANY

Complete Name - Required _____

Street Address Line 1 - Required _____

Street Address Line 2 _____

City, State Zip Code - Required _____

DATES OF ENROLLMENT APPLYING FOR: _____ **To:** _____

Effective Date and Expiration Date are REQUIRED (Must coincide with dates of underlying coverage if applicable)

LIST ALL LOUISIANA HEALTHCARE PROVIDERS MANAGED BY ABOVE COMPANY:

Does the company manage other healthcare related facilities outside of LA? No Yes

If yes, in what states? _____

For Self Insured, I further certify that the appropriate security (proof of financial responsibility) is in place and current at the following institution: _____

in the name of: _____

For those with primary insurance, please provide a copy of the COI or declarations page from the insurer's policy.

09/14/2023

DATE **SIGNATURE OF AUTHORIZED REPRESENTATIVE**

CONTACT PERSON

NAME: _____

PHONE #: _____

EMAIL: _____

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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