LOUISIANA PATIENT•S COMPENSATION FUND MD & ADVANCED PRACTICE RN•S APPLICATION

(FOR THOSE WITH PRIMARY INSURANCE)

1: PROVIDER DETAILS

***Complete Name & Mailing Address

Complete Name - Required

Street/Mailing Address Line 1 - Required

Street/Mailing Address Line 2

City, State Zip Code - Required

LICENSE #: License Number - Required

Date of Birth: Date of Birth - Required

Professional Specialty: Professional Specialty - Required

PCF Code:

Phone #: **EMAIL:**

If advanced practice nurse, name of supervising MD:

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)*:**

http://www.doa.la.gov/Pages/pcf/Index.aspx

Policy Form: ____ **Claims Made*** OR Occurrence** ____ Policy Form Selection - Required

Primary Premium: **PCF Surcharge:**

Professional Liability Limits: **Each Claim/** **Aggregate**

Do you work less than 20 hours per week? ☐ **No** **Yes** ☐ **If so, complete PCF12**

***IF COVERAGE IS IN PLACE FOR A CORPORATION, PLEASE PROVIDE A SEPERATE CERTIFICATE OF INSURANCE AND A CORPORATION APPLICATION (PCF9), WHICH CAN BE FOUND ON OUR WEBSITE: http://www.doa.la.gov/Pages/pcf/Index.aspx

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.

Are you employed by a facility as a Medical Director? ☐ **No** **Yes** ☐

Please indicate which of the following medical/surgical procedures you engage in:

☐	**Acupuncture**	☐	**Hysterectomies**	☐	**Otorhino/Plastic**
☐	**Administer General Anesthesia**	☐	**Intensive Care Medicine**	☐	**Otorhino/Surgery**
☐	**Amputations - Specify**	☐	**Laparoscopy**	☐	**Pain Management**
☐	**Angiography**	☐	**Laser Procedures - explain**	☐	**Plastic Surgery**
☐	**Appendectomies**	☐	**Liposuction**	☐	**Saddle Blocks**
☐	**Assist in Surgical Procedures**	☐	**Major Surgery in E.R.**	☐	**Skin Grafts**
☐	**Bariatric/Obesity Surgery**	☐	**Needle Biopsies**	☐	**Spinal Anesthetics/Epidural**
☐	**Cardiac Catheterization**	☐	**Nerve Blocks**	☐	**Spinal Surgery**
☐	**Cardiovascular Surgery**	☐	**Neurosurgery**	☐	**Tonsillectomies and/or Adenoidectomies**
☐	**Cesarean Sections**	☐	**Obstetrical Deliveries**	☐	**Telemedicine/Teleradiology**
☐	**Colon & Rectal Surgery**	☐	**Obstetrical Procedures**	☐	**Thoracic Surgery**
☐	**Colonoscopy**	☐	**Open Reductions of Fractures**	☐	**Traumatic Surgery**
☐	**D & Cs / Abortions**	☐	**Open Spinal Procedures (Non-Diagnostic)**	☐	**Tubal Ligations**
☐	**Dermabrasions**	☐	**Ophthalmology Surgery**	☐	**Urological Surgery**
☐	**Electroshock Therapy**	☐	**Oral Surgery**	☐	**Vascular Surgery**
☐	**Emergency Medicine**	☐	**Orthopedic Surgery w/Spine**	☐	**Vasectomies**
☐	**Hand Surgery**	☐	**Orthopedic Surgery - No Spine**		
☐	**Hemorrhoidectomies**	☐	**Orthopedic - Minor Surgery**		

Amputation Specify:

Explanation of Laser Procedures:

***** CLAIMS MADE POLICY**

Your primary insurance policy provides CLAIMS MADE coverage for professional liability. Except to the extent as may otherwise be specifically provided in your policy, such primary coverage is limited to claims arising from medical incidents occurring on or after the initial effective date stated in the declarations (?retroactive date?) and first reported to your company while the policy is in force. HOWEVER, THE PCF RETROACTIVE DATE IS THE DATE OF YOUR QUALIFICATION WITH THE FUND, WHICH MAY OR MAY NOT MATCH THE RETROACTIVE DATE ESTABLISHED ON YOUR PRIMARY POLICY. Claims occurring prior to the qualification date with the Fund, REGARDLESS OF THEIR COVERAGE THROUGH YOUR PRIMARY POLICY, are not covered by the Fund.

It is further acknowledged that in the event of termination of policy herein, or any endorsed reduction of liability limits, such termination or change shall not be effective unless such notice of the same has been delivered to the Louisiana Patients? Compensation Fund not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Mail, a copy of which shall have been mailed to the Health Care Provider.

3: LOUISIANA PATIENT'S COMPENSATION FUND

It is agreed that the insured under the above primary limits has been advised by the Company's Agent:

(1) that he or she is eligible to qualify for coverage under the Louisiana Patients' Compensation Fund for the provisions of La. R.S. 40:1231.1 et seq., as a "health care provider" that is already carrying underlying malpractice liability coverage at limits of $100,000/$300,000 or more:

(2) that to qualify, the insured undertakes to pay the required surcharge, and this surcharge will be collected by the Company's Agent if applicable, and remitted to the Fund on a calendar-year basis; and

(3) that if qualified, the insured is entitled to a $500,000 limitation of malpractice liability for death, or injury to any person and to coverage under that Fund for an excess liability (over the minimum underlying limits required by the Fund) up to a per claim limit of $500,000.

(4) I understand that, regardless of the retroactive date established by my primary policy, I will only receive coverage through the Fund for claims which occur after my qualification with the Fund. For a claim to be covered by the Patients' Compensation Fund, I must have been qualified with the Fund both at the time the medical incident occurred, and at the time the claim was filed with my primary carrier.

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

09/14/2023

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

PCF coverage is subject to all agreements, conditions and exclusions of the underlying policy unless such agreements, conditions and exclusions are expressly prohibited by law.

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