

**LOUISIANA PATIENT'S COMPENSATION FUND**  
**NURSING AND ASSISTED LIVING FACILITY APPLICATION**  
**(for those with underlying self-insurance)**

Your attention is directed to LAC 37:III, Chapter 11, §§1101-1105, which sets forth the cost and reserve reporting requirements which you must satisfy within the time allotted therein. Please note §1105 which provides for the cancellation of and termination of enrollment with the Patients' Compensation Fund for failure to comply with these reporting requirements.

**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.

DATE

**SIGNATURE OF ADMINISTRATOR**

CONTACT PERSON AND PHONE #:

EMAIL ADDRESS:

**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](mailto:pcf-surcharge@la.gov)

**A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.**