IPFCF
Injured Patients & Families Compensation Fund

Injured Patients and Families Compensation Fund
125 South Webster Street, P.O. Box 7873 | Madison, WI 53707-7873
p: 608-707-5481 | ociipfcf@wisconsin.gov | oci.wi.gov/ipfcf

Tony Evers, *Governor of Wisconsin*
Nathan Houdek, *Commissioner of Insurance*

Request for Retroactive Coverage – Financial
Ref: Sections Ins 17.25 (10) (cm) and 17.28 (3s) (c), Wis. Adm. Code

This form will be valid for 120 days from date of signature.

I am requesting retroactive coverage from the Injured Patients and Families Compensation Fund for the following period(s): .

I have no notice of any pending claim alleging malpractice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim for the period of time for which retroactive coverage is being requested.

Name	Account #	Provider's Email	Provider's Phone

Subscribed and sworn before me

This _____ day of _____, _____

_____
Notary Public

_____
County, State

My commission _____

Explain the circumstances involved in the failure to pay IPFCF fees on a timely basis (attach additional pages as necessary; attach any supporting documents).

Responsible party for payment		
Name of Individual (If Known):	Employer/Staff Agency Name:	Date Lack of Coverage was Discovered by Provider:
Party Phone Number:	Party Email:	

Email to ociipfcf@wisconsin.gov