DISTRICT OF COLUMBIA MID-YEAR SERVICE VERIFICATION FORM

This Report is due April 30th

Participant Contract/Service Year _____ ○HPLRP Participant ○J-1Visa Participant ○NIW Participant

_____

First Name Middle Name Last Name

_____

Street City State Zip Code

Home Number: _____ Cell Number: _____ E-Mail _____

1. I maintain a full-time clinical practice at: *(If more than one medical practice address, please copy and complete this form.)*
   Name of Medical Practice: _____

   _____

   Street Address City State Zip Code

   Telephone Number: _____ Fax Number: _____

2. Record office hours for the reporting period (use "X" for days not usually practicing). DO NOT include "on call" status time.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From:							
To:							

3. During the reporting period, approximately _____ hours/week were required to treat hospitalized patients of the practice at _____ Hospital(s).
4. My Medicaid Provider Number is: _____
5. The Provider Number the practice bills Medicaid is:_____
6. My DC Healthcare Alliance Provider Number is: _____
7. The Provider Number the practice bills the DC Healthcare Alliance is:_____

CERTIFICATION (To be completed by provider)

I CERTIFY THAT THE ABOVE REPORTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REFLECTS ACTIVITIES TO THE FULFUILLMENT OF MY OBLIGATION TO THE APPLICABLE PROGRAM.

_____ _____ _____

Provider's Name: (Print or Type) Provider's Signature Date

ENDORSEMENT (To be completed by practice)

I HAVE REVIEWED THE ABOVE REPORT BEING SUBMITTED BY _____WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE.

Practice Name: _____

Print Name: _____ Title: _____

Signature: _____ Date: _____

Save Form Submit Form