



DISTRICT OF COLUMBIA END-OF-YEAR SERVICE VERIFICATION FORM



This Report is due October 30th

Participant Contract Service/Year _____ J-1 Visa Participant [] or HLRP Participant []

First Name _____ Middle Name _____ Last Name _____

Street _____

City _____ State _____ Zip _____

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: _____

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 spent to treating hospitalized patients of the practice at _____ Hospital(s).

4. For this reporting period: *(If not applicable, put N/A)*

- a) Number of office visits (do not include telephone consultations or hospital visits) _____
- b) Number of hospital visits _____
- c) Number of patient visits for which Medicaid claims were submitted _____
- d) Number of patient visits for which DC Healthcare Alliance claims were submitted _____
- e) Number of patient visits for which services were rendered at a rate less than the usual and customary fee _____
- f) Number of patient visits for which no charges were made (based on inability to pay) _____

5. The Medicaid Provider Number used for billing my services is: _____

6. The DC Healthcare Alliance Provider Number used for billing my services 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 RELATED TO THE FULFILLMENT OF MY OBLIGATION TO THE PROGRAM.

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

ENDORSEMENT (To be completed by provider)

I HAVE REVIEWED THE ABOVE REPORT BEING SUBMITTED BY _____ TO BE THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE.

Practice Name: _____

Print Name: _____ Title: _____

Signature: _____ Date: _____