# DISTRICT OF COLUMBIA END-OF-YEAR SERVICE VERIFICATION FORM

*This Report is due October 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. For this reporting period: *(If not applicable, put NA)*

   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 charge was made (based on inability to pay) _____

5. My Medicaid Provider Number is: _____
6. The Provider Number the practice bills Medicaid is: _____
7. My DC Healthcare Alliance Provider Number is: _____
8. 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