DISTRICT OF COLUMBIA EN	ID-OF-YEAR SERVICE VERIFICATION FORM
	41-

<u>* * *</u>

Practice Name:

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Print Name:

Signature:

* * *

This Report is due October 30 th	
 HPLRP Participant	J-1V

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:	First Name	Middle Name			Last Name		
Name of Medical Practice:	Street	City				State	Zip Code
Name of Medical Practice:	Home Number:		Cell Numb	ber:	E-M	ail	
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 rom:		-			-		•
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 rom:	Street Address			City		State	Zip Code
Sunday Monday Tuesday Wednesday Thursday Friday Saturday rom:	Telephone Numb	oer:		F	Fax Number: ——		
Sunday Monday Tuesday Wednesday Thursday Friday Saturday rom:	2 Perord office h	ours for the repor	ting period (use "	V" for days not usu	ally practicing) D	O NOT include "on (call" status time
rom:		-		-			
To:		Wonday	Tuesday	Wednesday	Thursday	Thay	Suurduy
3. During the reporting period, approximately hours/week were required to treat hospitalized patients of the practice :	rom:						
4. For this reporting period: (If not applicable, put NA) a) Number of office visits (do not include telephone consultations or hospital visits) (If not applicable, put NA) a) Number of hospital visits (If not applicable, put NA) b) Number of hospital visits (If not applicable, put NA) c) Number of patient visits for which Medicaid claims were submitted (If not applicable, put NA) d) Number of patient visits for which DC Healthcare Alliance claims were submitted (If not applicable, put NA) e) Number of patient visits for which DC Healthcare Alliance claims were submitted (If not applicable, put NA) e) Number of patient visits for which be revices were rendered at a rate less than the usual and customary fee (If not applicable, put NA) f) Number of patient visits for which no charge was made (based on inability to pay) (If not applicable, put NA) 5. My Medicaid Provider Number is: (If not applicable, put NA) 6. The Provider Number the practice bills Medicaid is: (If not applicable, put NA) 7. My DC Healthcare Alliance Provider Number is: (If not applicable, put NA) 8. The Provider Number the practice bills the DC Healthcare Alliance is: (If not applicable, put NA) ICERTIFY THAT THE ABOVE REPORTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND (ICERTIFY THAT THE ABOVE REPORTED INFORMATION IS CORRECT TO THE APPLICABLE PROGRAM.	To						
5. The Provider Number the practice bills Medicaid is:	3. During the repor		-		-		_Hospital(s).
7. My DC Healthcare Alliance Provider Number is:	 3. During the repor 4. For this reporting a) Number of b) Number of c) Number of d) Number of e) Number of 	g period: office visits (do not hospital visits patient visits for patient visits for patient visits for patient visits for	not include teleph which Medicaid of which DC Health which services w which no charge	one consultations of claims were submitt acare Alliance claim ere rendered at a rat was made (based or	r hospital visits) ed s were submitted te less than the usua i inability to pay)	(If not	Hospital(s). applicable, put NA)
The Provider Number the practice bills the DC Healthcare Alliance is: <u>CERTIFICATION</u> (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	 During the reporting For this reporting a) Number of b) Number of c) Number of d) Number of e) Number of f) Number of f) Number of 	g period: office visits (do not hospital visits patient visits for patient visits for patient visits for patient visits for patient visits for patient visits for	not include teleph which Medicaid of which DC Health which services w which no charge	one consultations of claims were submitt neare Alliance claim rere rendered at a rat was made (based or	r hospital visits) ed s were submitted te less than the usua n inability to pay)	(If not	Hospital(s). applicable, put NA)
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 Title:

Date: _____
