



DISTRICT OF COLUMBIA MID-YEAR SERVICE VERIFICATION FORM

This Report is Due April 30th.



Participant Contract Year _____

J-1 Visa Participant Yes ☐ No ☐

HPLRP Participant Yes ☐ No ☐

First Name _____ Middle Name _____ Last Name _____

Street _____

City _____ State _____ Zip _____

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

(If more than one medical practice address, please copy and complete this form.)

1. I maintain a full-time clinical practice at:

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 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

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

Provider's Name: (Print or Type) _____

Provider's Signature _____

Date _____

ENDORSEMENT

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: _____

(Please scan and email to HPLRP@dc.gov)