GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

Insurance Verification Request:

I, _____ _____
Licensee Signature Facility Address

authorize on this date_____ the release and verification of the requested information regarding policy(ies) issued for the above listed premise(s).

The maximum capacity of residents in this facility is _____.

Insurance Company _____

Address _____

_____Telephone Number: _____

Please verify that the above named licensee has current insurance policy(ies) with your company that provides coverage for non-related residents who pay for their care. Please complete the appropriate areas below:

Hazard (fire and extended coverage) $ _____

Policy Number _____Effective Date_____ Expiration Date _____

Liability coverage (1) Premises, personal injury, and products _____

(2) Professional liability $_____

Policy Number _____Effective Date_____ Expiration Date_____

Signature _____
Insurance Representative

Return to:

Health Regulation and Licensing Administration
899 North Capital Street, N.E., 2nd Floor
Washington, D.C. 20002

HRLA – Form 101/2000