# 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 FULFUILLMENT 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)*

Save Form Submit Form