DISTRICT OF COLUMBIA END-OF-YEAR SERVICE VERIFICATION FORM

This Report is due October 30th

Participant Contract Service/Year _____ J-1 Visa Participant ☐ or HLRP Participant ☐

First Name Middle Name Last Name

Street

City State Zip

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: _____

   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 spent to treating hospitalized patients of the practice at _____ Hospital(s).

4. For this reporting period: *(If not applicable, put N/A)*

   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 charges were made (based on inability to pay) _____

5. The Medicaid Provider Number used for billing my services is: _____

6. The DC Healthcare Alliance Provider Number used for billing my services 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 RELATED TO THE FULFULLMENT OF MY OBLIGATION TO THE PROGRAM.

_____ _____ _____

Provider's Name: (Print or Type) Provider's Signature Date

ENDORSEMENT (To be completed by provider)

I HAVE REVIEWED THE ABOVE REPORT BEING SUBMITTED BY _____ TO BE THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE.

Practice Name: _____

Print Name: _____ Title: _____

Signature: _____ Date: _____

Save Form Submit Form