Diabetes Care Incentive Program Verification Form

Participant Information:

Full Name:_____

Date of Birth (MM/DD/YYYY):_____

Phone Number:_____

Email Address:_____

Completed Activity (Check One):

☐ Eye Exam

☐ Dental Cleaning/Exam

☐ Foot Exam

☐ A1C Test

Appointment Details:

Date of Service:_____

Clinic/Facility Name:_____

Healthcare Provider Verification:

I verify that the above-named patient has completed the selected activity.

Provider Signature:_____

Date:_____

Participant Attestation:

I certify that the information provided is accurate and that I have completed the selected activity as stated.

Participant Signature:_____

Date:_____

Submission Instructions:

Submit this completed form via:

Email: diabetes@samishtribe.nsn.us

Mail:

Samish Indian Nation

PO BOX 217

Anacortes, WA 98221

ATTN: Olivia Duvall TWC