PRIMARY CARE VERIFICATION FORM

Purpose: To ensure that Ryan White clients are annually enrolled in primary care

Provider Instructions:

As a part of SUBRECEPIENT NAME Ryan White contractual obligations, clients are required to enroll annually in primary care services. SUBRECEPIENT NAME is NOT requesting any medical records or PHI pertaining to this enrollment. Once the enrollment is complete, please sign and date this form then return it to the client. If you have any questions, please reach out to us at ……

Primary Care Services Description:

The annual primary care enrollment should include a medical and health history discussion, a lipid panel, glucose test, blood pressure, height, weight, BMI, annual OB/GYN exam for women, and any other age and gender appropriate screenings.

Verification:

Provider’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I verify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Patient’s name*) is enrolled in our facility for primary care services on the date specified above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Signature



Patient Release:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (*Patient’s name*) authorize my primary care provider listed in “Verification” section of this form to release my annual primary care status for use in SUBRECEPIENT NAME Ryan White program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date