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: 715 Seafarers Way STE 100 Anacortes, WA 98221 ATTN: DCIP