Provider Verification of Identity

Instructions

For use by medical providers only. A medical provider may use this form to attest to an ADAP or PrEP-AP applicant's identity when the applicant is unable to provide one of the following required documents to establish his or her identity:

- •Driver's license
- •Permanent Residence Card
- •Military identification card
- •State identification card
- •Employment authorization card
- •Photo identification issued by a foreign government
- •U.S. Passport
- •Birth certificate

Applicant Information

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I attest that I do not have access to one of the identification documents listed above to verify my identity. I hereby grant the provider named below permission to attest to my identity. I attest that, to the best of my knowledge, the information provided in this form, and in all other documents submitted in conjunction with this form, is true and accurate. I understand and hereby acknowledge that CDPH may request additional documentation to verify my identity if there is reason to believe additional verification is necessary. I understand that failure to provide accurate information or deliberately omitting information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

Applicant Signature:_____ Date:_____

Provider Information

Name:_____ Title:_____

National Provider Identifier (NPI):_____ Phone:_____

Hospital/Clinic Name:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I attest that the above-named applicant has been a patient at the hospital/clinic indicated above since _____(enter date), and that he or she is unable to submit one of the identification documents listed above to verify his or her identity.

I certify that (Required. Select all that apply):

☐ I have obtained other documentation provided by the above-named applicant which I have reason to believe is authentic and satisfactorily establishes the identity of the above-named applicant.

☐ I have sufficient knowledge of the above-named applicant to attest to his or her identity and to the authenticity of his or her name and date of birth as indicated above.

Provider Signature:_____ Date:_____