MedStar Family Choice

Identity Verification Form

Please complete and sign this form.

Parent/Guardian First and Last Name_____

Medicaid ID Number(if a Medicaid Recipient): _____

Date of Birth (DOB): ___ / ___ / _____

MFC ID number (if applicable) _____

Mailing Address _____

_____

City, State, Zip _____

E-mail _____ Phone: _____

Child (Minor) whose records you wish to Access

Minor First Name: _____ Minor Last Name: _____

Minor Medicaid ID Number: _____Minor MFC ID Number:_____

Minor DOB: ___ / ___ / _____

Are you the parent or guardian of this Minor? ☐ Yes / ☐ No

I affirm I am attaching a copy of one of the following documents to prove my identity:

☐ Valid state ID ☐ Medicaid ID Card (front and back)

I hereby affirm under the penalties of perjury that the foregoing statements are true to the best of my information, knowledge, and belief.

Signed: _____

Print name: _____ Date: _____

It's how we treat people.