

**Wisconsin
HHA OASIS Assessment Deletion Request**

Date of Request: _____

HHA Contact Name: _____

HHA Contact Phone Number: _____

HHA Name	
HHA_ID	
(M0020) Patient ID	
(M0040) Patient Last Name	
(M0040) Patient First Name	
(M0064) SSN	
(M0100) Assessment Reason	
*Effective Date	
Submission Date/Time	
Submission Batch ID	
Reason this data should be removed from State's OASIS database	

*Effective dates are (M0030_START_CARE_DT for RFA 01, 02; M0032_ROC_DT for RFA type 03; M0090_INFO_COMPLETED_DT for RFA types 04, 05; M0906_DC_TRAN_DTH_DT for RFA types 06, 07, 08, 09, 10)

Fax or mail this form to:

Chris Benesh
 Division of Quality Assurance
 P.O. Box 2969
 Madison WI 53701-2969
 Fax: (608) 267-7119