DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13150 (04/2019)

STATE OF WISCONSIN
P.L. 104–191

WISCONSIN MEDICAID

CONFIDENTIAL OR ALTERNATIVE COMMUNICATION REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law 104–191 requires the Wisconsin Department of Health Services (DHS), as a covered entity, to implement processes that give members certain rights regarding individually identifiable health information. Members have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. Although the use of this form is voluntary, the information requested is required for us to process your request.

INSTRUCTIONS: Mail this completed form to the following address:

Wisconsin Medicaid
Member Services
PO Box 6678
Madison, WI 53716-0678

SECTION I – MEMBER INFORMATION

Name – Last, First, Middle Initial	Wisconsin Medicaid Identification Number

Street Address

City	State	Zip Code	Phone Number

SECTION II – ALTERNATIVE COMMUNICATION REQUEST

Read the following and complete the information requested.

You have the right to request how and where Medicaid contacts you about your information. The Division of Medicaid Services will accommodate reasonable requests if you provide a reasonable alternative means or location for communicating with you. To exercise this right, complete the following.

Describe the information you wish to have communicated in an alternative manner.

- ☐ Notice of injuries
- ☐ Care plans
- ☐ General updates
- ☐ Medical records
- ☐ Medication records
- ☐ Professional reports
- ☐ Annual program reviews
- ☐ Dental reports
- ☐ Quarterly reports
- ☐ Therapy reports
- ☐ Identifying information (such as Social Security or Medicaid ID number)
- ☐ Other:

I request that you communicate with me by the following alternative means (list how you want to receive this information below).

- ☐ Encrypted email
- ☐ Nonencrypted email
  I understand the risk of receiving records via unsecured email and that information could be accessed by a third party while in transit. I still want these records in this manner.

Email Address

☐ Voicemail—list number below	☐ Fax—list number below	☐ Cell Phone—list number below

☐ Other—specify below

This consent may be revoked any time by giving written notification.

SECTION III – SIGNATURES

Sign the form and complete the appropriate information.

SIGNATURE – Member	Date Signed

NOTE: If this request is from a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following

Name – Personal Representative	Relationship to Member

SIGNATURE – Personal Representative	Date Signed

RESET FORM