WISCONSIN MEDICAID
HIPAA PRIVACY ALTERNATE COMMUNICATION REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHS, as a covered entity, to implement processes that give members certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

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
Address — Street, City, State, ZIP Code	Telephone Number ( )

SECTION II — ALTERNATIVE COMMUNICATION REQUEST

Please read the following and complete the information requested.

You have the right to request how and where Medicaid contacts you about your medical information. The Wisconsin Division of Health Care Access and Accountability (DHCAA) will accomodate reasonable requests if you provide a reasonable alternative means or location for communicating with you. To exerise this right, please complete this form. NOTE: The DHCAA does not routinely communicate protected health information to members, since the DHCAA does not provide the health care or treatment directly to you.

Describe the protected health information you want subjected to alternative communication:

_____

_____

☐ I request that the DHCAA communicate with me about my protected health information by the following alternative means. Provide full information on the alternative means you want used by the DHCAA:

_____

_____

☐ I request that you communicate with me about my protected health information at the following alternative location. Provide full information on the alternative location:

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Continued

SECTION III — SIGNATURES

Please sign the form and complete the appropriate information.

SIGNATURE — Member	Date Signed

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