DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13152 (08/2018)

STATE OF WISCONSIN
P.L. 104–191

WISCONSIN MEDICAID

HIPAA PRIVACY COMPLAINT

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 address below.

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

SECTION I – MEMBER INFORMATION

Name – Member (last, first, MI)	Member ID	Phone Number

Street Address		

City	State	Zip Code

SECTION II – COMPLAINT POLICY SUMMARY

You have the right to file a complaint with the Division of Medicaid Services (DMS) about our compliance with our *Notice of Privacy Practices* or our privacy policies and procedures. DMS will investigate your complaint and provide you with our written response. DMS will not require you to waive any rights you may have under federal or state privacy or other law to file your complaint, nor will filing your complaint affect the payment made by DMS for the health care provided to you. Further, you will not lose benefits or eligibility or otherwise be retaliated against for filing a complaint. To exercise this right, complete, sign, and date this form and then mail this complaint to the address listed above.

If you have questions or need additional information or assistance in completing your complaint, contact Member Services at 800-362-3002. You may, in addition to or instead of filing a complaint with DMS, file a complaint with the United States Department of Health and Human Services. For information on the procedure for doing this, please contact DMS at the above location or call Member Services at 800-362-3002.

SECTION III – MEMBER'S COMPLAINT

Give a concise statement of your complaint.

Give a concise statement of the resolution you seek for your complaint.

SECTION IV – 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