DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13157 (08/2020)

STATE OF WISCONSIN
P.L. 104-191

WISCONSIN CHRONIC DISEASE PROGRAM (WCDP)

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 patients 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:

WCDP
Member Services
PO Box 6410
Madison WI 53716

SECTION I – MEMBER INFORMATION

Name – Last, First, Middle Initial	WCDP Identification Number
Address – Street, City, State, ZIP Code	Phone Number ( )

SECTION II – AMENDMENT REQUEST

Please read the following and complete the information requested.

You have the right to ask for a correction to enrollment, claim, or other records used to make decisions about your health plan services that the Wisconsin Chronic Disease Program (WCDP) or our business associates maintain. The WCDP may decline your request if the information is not part of the protected health information we create, the information requested to be amended is complete and accurate in our assessment, or the information is not accessible to you as a member. To exercise your right to request this amendment, please complete this form.

Specify the records, and the dates of the records, you wish to amend and the amendments you wish to make:

_____

_____

State the reasons for the amendments: _____

_____

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