Request for Access to
Protected Care Management Information

My Choice Wisconsin
Attention: Member Records Coordinator
1617 Sherman Ave.
Madison, WI 53704
Phone 608 245-3109 Fax 608 245-3107

I, ____ Date of Birth _________________________
(Legal Name)

Hereby request to copy of my care management records for the following dates.____________________
__________________________________that My Choice Wisconsin maintains in the designated record set. I request the care management records containing the following:

______Enrollment records
______Assessment summaries
______My Choice Nurse care records/notes
______My Choice Care Coordinator records/notes
______Member Center Care Plans
______Service Plans
______In Home Care Plans (IHCP)
______Long Term Care Functional Screens (LTCFS)
______Cost Share payments
______Claims, billing and (EOB) Information relating to the following service or claim: (specify date of service and/or medical condition) ____
______Other.____

I understand that I may access a copy of my care management records through the following methods:

______I prefer a printed copy of the requested information to be viewed at a My Choice Wisconsin office in person at a mutually convenient time by calling the Member Coordinator at 608 245-3109. Records will then be shredded.

______I prefer to have the requested information printed and mailed to me at the following address:
____

I prefer to have the requested information provided electronically and securely emailed or faxed to me to the following email address or fax number:
____

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Signature of Member/ Guardian/ activated POAHC Date signed

If signed by Guardian/activated POAHC legal papers must be on file with My Choice Wisconsin.