

LA CROSSE COUNTY CHILD SUPPORT

333 Vine Street, Room 1701
La Crosse, WI 54601
Fax #: 608-785-5760

Request for Medical Status

Medical Provider: Please attach this report to letterhead from your organization with a brief letter notating your response and your signature for validity purposes.

Payor/Patient Name: _____ Date of Birth: _____

Medical Provider Facility: _____

Treatment Provider Name: _____ Date of Treatment: _____

Diagnoses (particularly those that affect ability to work):

Please describe the treatment provided:

If this is not a new patient, is the patient complying with recommended treatment?

Yes No If no, what is the patient failing to do?

Is the patient, in your medical opinion, currently able to work?

Yes (no limitations) Yes (with limitations) No

If the answer is Yes, with limitations, please describe the limitations and the next treatment date:

If the answer is no, indicate the expected duration of the inability to work and the next treatment date:

Treatment Provider Signature

Date

This request for information is being made in accordance with 42 U.S.C. 654, which requires that each state use all available sources of information to locate absent parents or alleged absent parents. This information will be used solely to enforce Wisconsin child support laws. The information will not be used for commercial purposes or private gain. You are authorized to release this information by s. 49.22 (2m), Wis. Stats. Please give the most recent information you have and date it was valid. Return the completed form to the agency address above. A covered entity under the Health Insurance Portability and Accountability Act (HIPPA) may disclose protected health information to the extent that disclosure is required by law or to an agency performing a government regulatory program [45 C.F.R. s. 164.512(a) & (d)(1)(iii)].