

## LA CROSSE COUNTY CHILD SUPPORT

333 Vine Street • Room 1701

La Crosse, WI 54601-3296

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: \_\_\_\_\_

**Please select ONE of the following options:**

\_\_\_\_ Patient is PERMANENTLY TOTALLY DISABLED as of \_\_\_\_\_ (date) OR

\_\_\_\_ Patient is TEMPORARILY TOTALLY DISABLED as of \_\_\_\_\_ through \_\_\_\_\_ and will be reevaluated on \_\_\_\_\_ (date) OR

\_\_\_\_ Patient is (Choose one: PERMANENTLY or TEMPORARILY PARTIALLY DISABLED and has the following work restrictions as of \_\_\_\_\_ (date) OR will be released to return to work without restrictions on \_\_\_\_\_ (date).

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

☐ Yes ☐ No If no, what treatments 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 (no stamp)**

\_\_\_\_\_  
**Date**

Name:

Address:

City:

State:

Phone:

Please return to:

La Crosse County Child Support Agency

333 Vine Street, Room 1701

La Crosse, WI 54601

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)].