4318 W. Forest Home Ave., Suite 1
Milwaukee, WI 53219
Tel: (414) 435-0565
Fax: (414) 327-4307

EVV Correction Request Form

Client Name: _____

PCW Name: _____

What visit being corrected: _____/_____/_____ _____
Date Time

Time In is correct? Yes ☐ No ☐ if No, what is the correct **Time In**? _____

Time Out is correct? Yes ☐ No ☐ if No, what is the correct **Time Out**? _____

Are the provided services/tasks marked correctly? Yes ☐ No ☐ if No, what are the correct services/tasks were provided during the shift?

Bathing	☐	Meal preparation	☐
Dressing	☐	Light cleaning	☐
Grooming	☐	Laundry	☐
Mobility	☐	Linen change	☐
Toileting	☐	Food shopping	☐
Transferring	☐	Dishes	☐
Medication Assistance	☐	Ted / Braces	☐

Please describe the reason(s) for the correction_____

_____

Please review the completed form for accuracy before signing. It is a federal crime to provide false information for Medicaid payment. Your signature verifies the time and services listed above are accurate and correct.

Client Signature: _____ **Date**: _____

PCW Signature:_____ **Date**: _____