

Request for Waiver of Monthly Face-to-Face Visit for Home Dialysis Monthly Capitation Payment (MCP)

Attention: Medicare Medical Review Department

Provider Name _____ PTAN/NPI # _____
Provider Contact _____ Contact Phone # _____
Provider Address _____
City _____ State _____ Zip Code _____
Patient name _____ HIC # _____
Month/Year Requested for Waiver _____

Please submit the following information to:

**WPS – Medicare
Attention: Medical Review Department
1717 West Broadway
Madison, WI 53713**

- Documentation to support a waiver of care will include:
 - Completed Waiver Request from Physician
 - Physician Notes documenting active & adequate care of the home dialysis patient throughout the month (i.e. phone calls to beneficiary, interaction with dialysis center)
 - Current Lab report values: Hemoglobin x3 or hemoglobin/hematocrit; serum Erythropoietin (EPO level); Blood Urea Nitrogen (BUN); serum Creatinine, Chloride, Iron, Potassium, Sodium, Calcium; Transferritin; Ferritin; most recent Phosphorus (phosphate) and Kt/V.
 - Documentation of approval for Home Dialysis Regimen or Required change for month of waiver.