

**WISCONSIN MEDICAID**  
**VERBAL ORDERS FOR RECERTIFICATION: HOME HEALTH AGENCY REQUEST FOR**  
**VARIANCE OF PHYSICIAN SIGNATURE REQUIREMENT**

**Instructions:** Print or type clearly. Refer to the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement Completion Instructions, F-01017A, for detailed information on completing this form.

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**SECTION I — HOME HEALTH AGENCY INFORMATION**

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Name — Home Health Agency

Telephone Number — Agency

Agency's Wisconsin Medicaid Provider Number

Address (Street, City, State, and Zip Code) — Agency

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The previously listed home health agency requests a Wis. Admin. Code § DHS106.13 Discretionary Variance of provisions in Wis. Admin. Code §§ DHS 107.11(6)(b)4, 107.113(2), and/or 107.12(1)(d)2.

Wisconsin Medicaid requires home health agencies to be Medicare certified. A home health agency is required to comply with Medicare conditions of participation to maintain Medicare certification, including the completion of the Outcome and Assessment Information Set between days 55 and 60 of each 60-day certification period. Complying with this Medicare requirement reduces the amount of time the home health agency has to comply with Wisconsin Medicaid's requirement to have a physician review the member's plan of care (POC) and obtain the physician's dated signature on the member's written POC. Therefore, strict enforcement of the Wisconsin Medicaid physician signature requirement would result in unreasonable hardship on the provider.

The home health agency named in this section requests a discretionary variance that permits the agency to have a physician review the member's POC and obtain the physician's dated signature on the member's written POC under the same Wisconsin Medicaid requirement for obtaining the physician's dated signature for an initial certification period.

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**SECTION II — HOME HEALTH AGENCY ATTESTATION**

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As an authorized representative for the home health agency named in Section I, I attest that if the variance is granted as requested in Section I, the agency will comply with the following condition:

The health, safety, and welfare of each member will not be adversely affected as a result of having a physician review the member's POC and obtaining the physician's dated signature on the member's written POC after the start of the recertification period. The agency shall receive and document verbal orders from the member's physician and send them to the ordering physician for his or her signature prior to the recertification period that the orders cover.

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Name — Authorized Representative of Home Health Agency (Print)

Title — Authorized Representative

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**SIGNATURE** — Authorized Representative of Home Health Agency

Date Signed

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**FOR OFFICE USE ONLY**

Date Variance Request Received by Wisconsin Medicaid

Date Variance Granted

Effective Date of Variance

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**Name** — Received by (Print)