



1717 W. Broadway • P.O. Box 8190 • Madison, WI • 53708-8190



THE EPIC LIFE INSURANCE COMPANY  
A WPS Company

RE: Home Attendance Care Services

Dear Member:

As a recipient of the Wisconsin Physician Services (WPS) Standard Plan policy, you may be eligible for Home Attendance Care benefits. By requesting this form, you have indicated that you believe you received Home Attendance Care Services within the last two years that you have been covered under this contract. Home Attendance Care benefits are described in the contract as:

**“...Charges for home attendance and care recommended by the attending Physician and provided by other than a registered or licensed practical nurse or a member of the participant’s family. The maximum benefit is 150 days at \$10.00 per day during the lifetime of the participant while the participant is covered under the contract.”**

Before payment can be considered, the following information is needed:

- Note from the member’s physician explaining medical need for services.
- Home Attendance Care Claim form (enclosed). Complete all areas of the form, including the signature of the caregiver, caregiver relationship and date(s) of service.

Please return the enclosed form with your physicians note to: WPS, PO Box 8190, Madison WI 53708. When the information is received and if the claim is approved, payment will be sent directly to you. It will be your responsibility to make payment to the caregiver.

If you have any further questions, please call 1-800-634-6448 Monday through Thursday from 7:00 AM to 7:00 PM and on Friday from 7:00 AM to 4:30 PM Central Standard Time.

Our commitment is focused on providing the very best service.

Sincerely,

Vickie Severson  
WPS Member Services

Enclosure

# HOME ATTENDANCE CARE CLAIM FORM

\_\_\_\_\_  
Member Name Member Identification #

\_\_\_\_\_  
Member Address City State Zip Code

Below, please fill out the date of service, what service was performed, signature of the caregiver (the person providing the service) and the relationship of the caregiver to the member.

Service Date	Service Provided	Caregiver Name	Caregiver Relationship

**Recommendation from an attending physician is required for services to be considered for reimbursement.**

I, \_\_\_\_\_, hereby verify that I provided Home Attendance  
Caregiver Name

Care Services to this member on the above referenced date(s) of service.

\_\_\_\_\_  
Caregiver Signature

\_\_\_\_\_  
Caregiver Address

\_\_\_\_\_  
Caregiver Phone Number