EXHIBIT 161
(Rev. 30, 12-15-07)

NOTICE OF INTERIM APPROVAL OF CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) SERVICES

(**Date**)

Provider Name
Address
City, State, ZIP Code

Re: ***CMS Certification Number (CCN)***

Dear (**Provider Name**):

We have considered your request to furnish directly continuous ambulatory peritoneal dialysis (CAPD) patient training and support services (which may be provided via an agreement or arrangement with another approved ESRD facility).

Your facility has been approved on a temporary basis to furnish CAPD training and support services, effective (**date**). This approval is subject to later review and reevaluation upon publication of specific regulations reciting program requirements, and Certificate of Need approval where required by State Law.

Your intermediary will contact you shortly to explain any special reimbursement procedures to be followed for CAPD. Use your *CCN*, shown above, on all billings and correspondence concerning CAPD services.

Should you have any questions regarding your furnishing of CAPD services, please contact this office.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

cc:
Fiscal Intermediary*/Medicare Administrative Contractor*
State Agency
Central Office