Remittance Advice Replacement Request Policy

To request a printed replacement copy of a Wyoming Medicaid Remittance Advice, complete the following steps:

- Print the Remittance Advice (RA) Replacement Request Form
- For replacement of a complete RA - contact Provider Relations at 800-251-1268, options 1, 5, 0 - to obtain the RA number, date, and number of pages
- Replacements of a specific page of an RA (containing a requested specific claim/TCN) will be 3 pages (the cover page, the page containing the claim, and the summary page for the RA)
- Review the below chart to determine the cost of the replacement RA (based on total number of pages requested – for multiple RAs requested at the same time, add total pages together)
- Send the completed form and payment as indicated on the form
  - Make checks to Division of Healthcare Financing
  - Mail to: Provider Relations, PO Box 667, Cheyenne, WY 82003-0667

The replacement RA will be emailed, faxed or mailed as requested on the form. Email is the preferred method of delivery, and RAs of more than 10 pages cannot be faxed.

RAs less than 24 weeks old can always be obtained from the Secure Provider Web Portal, once a provider has registered for access. For assistance with accessing the Secure Provider Web Portal, contact the EDI Call Center at 800-672-4959, option 3.

Total Number of RA Pages	Cost for Replacement RA
1 – 10	$2.50
11 - 20	$5.00
21 - 30	$7.50
31 - 40	$10.00
41 - 50	$12.50
51+	Contact Provider Relations for rates

Remittance Advice (RA) Replacement Request Form
(Print clearly)

Provider Name (as enrolled with Wyoming Medicaid): ___________________________________

Provider NPI: ____________________________ Provider Taxonomy: ___________________

OR

Wyoming Medicaid Provider ID: ___________________________

Please complete as much of the following as possible, to enable us to locate your requested RA:

To request a complete RA:

RA Number: ______________________

RA Date: ________________________

RA Amount: ______________________

To request a single RA page (includes cover sheet and summary and the page with the specific claim):

Specific Claim TCN: ____

Specific Claim Client ID and Date of Service: _________________________

Delivery Method (select one):

__ Email Address (preferred): ____

__ Fax Number (over 10 pages cannot be faxed): ___________________________________

__ Mailing Address: ____

Return this form, along with appropriate payment (make checks payable to the Division of Healthcare Financing), to:

Wyoming Medicaid
Attn: Provider Relations
PO Box 667
Cheyenne, WY 82003-0667

Enclosed Check Info:
Total Amount: ______________
Check Number: _____________

Your RA will be sent to you by your above chosen method within 10 business days of receipt.
Contact Provider Relations at 1-800-251-1268, press 1, 5, 0 for questions