**Instructions for filling out Attachment Cover Sheet**

**The information entered on this cover sheet must match the data entered in the 837 claim transaction, including the Attachment Control Number, TCN and Attachment Type. If information entered does not match electronic file/claim exactly, attachment will not be accepted.**

| Field | Action |
|---|---|
| Pay to (Group) Name | Complete with the name of the Pay to/Group Provider |
| Pay to (Group) NPI | Complete with the ten digit NPI number for the Pay to/Group Provider |
| Client Name | Complete with the client's full name |
| Medicaid ID Number | Complete with the client's Wyoming Medicaid ID number |
| Claim From Date of Service (MM/DD/YY) | Complete with the first date of service on the claim |
| Claim To Date of Service (MM/DD/YY) | Complete with the last date of service on the claim |
| Attachment Control Number (Required) | Complete with the attachment control number that was indicated on the electronic claim |
| TCN (Required) | Enter the TCN for the electronic claim |
| Attachment Type (Required) | Select the attachment type that was indicated on the electronic claim |

# Attachment Cover Sheet

Please use this form when submitting a claim electronically which requires attachments. The supporting documentation (EOB, medical records, etc.) must be attached to this cover sheet. If the documentation is received without a cover sheet the request CANNOT be processed and the documents will be shredded.

All information entered on this cover sheet must match the data entered in the 837 claim transaction, including the Attachment Type and Attachment Control Number. Also, the Attachment Transmission Code in the 837 claim transaction must be set to 'BM' (By Mail) to indicate the attachment is being sent separately.

**Pay-to Provider Name:** _____

**Pay-to Provider or NPI Number:** | | | | | | | | | | |

**Client Name:** _____

**Medicaid ID Number:** | | | | | | | | | | |

**Claim From Date of Service: (MM/DD/YY)** | | | | **Claim To Date of Service: (MM/DD/YY)** | | | |

**Attachment Control Number: (Required)** _____

**Must include no spaces and match the 837 file exactly**

**TCN: (Required)** | | | | | | | | | | | | | | | | |

**Attachment Type: (Required)**

- ☐AS: Admission Summary
- ☐B2: Prescription
- ☐B3: Physician Order
- ☐B4: Referral Order
- ☐CT: Certification
- ☐CK: Consent Form(s)
- ☐DA: Dental Models
- ☐DG: Diagnostic Report
- ☐DS: Discharge Summary
- ☐EB: Explanation of Benefits
- ☐MT: Models
- ☐NN: Nursing Notes
- ☐OB: Operative Notes
- ☐OZ: Support Date for Claim
- ☐PN: Physical Therapy Notes
- ☐PO: Prosthetics or Orthotic Certification
- ☐PZ: Physical Therapy certification
- ☐RB: Radiology Films
- ☐RR: Radiology Reports
- ☐RT: Report of Tests and Analysis Report

**RETURN THIS DOCUMENT WITH ATTACHMENTS TO:**

**Wyoming Medicaid**
**Attn: Claims**
**PO Box 547**
**Cheyenne, WY 82003-0547**