Instructions for filling out the Authorization of Medical Necessity Request Form – Clients Age 21 and Older

Field	Action
Pay to (Group) NPI	Complete with the ten digit NPI number for the Pay to/Group Provider
Pay to (Group) Name	Complete with the name of the Pay to/Group Provider
Taxonomy Code	Enter the taxonomy code for the pay to provider
Contact Email	Complete with the contact email address for the provider
Treating/Rendering NPI	Complete with the ten digit NPI number for the treating provider
Treating/Rendering Name	Complete with the name of the treating provider
Client ID	Complete with the client's Wyoming Medicaid ID number
Client Name	Complete with the client's full name
Client Age/DOB	Complete with the client's age at the time of the request and the date of birth
Authorization of Medical Necessity Year	Complete with the requested calendar year for the authorization of medical necessity
Authorization of Medical Necessity Begin/End Date	Complete with the dates the authorization of medical necessity will need to begin and when it will end
Frequency	Complete with the frequency of services needed (i.e. 3x/week)
Services Type	Check the appropriate box for which type services you are requesting
Date of Onset Condition	Complete with the date the onset condition began
Diagnosis Code	Complete with the diagnosis codes – up to four are allowed
Ordering Provider Name & NPI	Complete with the Name and NPI number for the ordering provider – this section is required for Speech, Occupational or Physical Therapy
Describe injury, illness, surgery or triggering event that initiated the need for services	Complete with what caused the acute condition (i.e. post-surgery, personal injury, auto accident, etc.)
Describe acute condition requiring rehabilitative services	A detailed explanation as to the diagnosis and rehabilitative need for services for acute conditions only. Indicate why the client has exceeded their threshold limit. For Behavioral Health services, ensure to include last 5 progress reports and treatment plan.
Describe anticipated rehabilitative progress and length of additional treatment	Describe the rehabilitative progress anticipated and the length needed for additional treatment. For physical, occupational, or speech therapy services, ensure you attach a copy of the practitioner's order.
Treating provider signature and date	The provider providing the services will need to sign and date the Authorization of Medical Necessity Form

Wyoming Department of Health

FOR DATES OF SERVICE ON OR AFTER NOVEMBER 1, 2017 – THIS FORM WILL NOT BE REQUIRED FOR OT, PT, ST OR BEHAVOIRAL HEALTH. YOU MUST CONTACT QUALIS HEALTH (1-800-783-8606) FOR PRIOR AUTHORIZATION FOR OT, PT, ST OR BEHAVIORAL HEALTH SERVICES.

Authorization of Medical Necessity – Clients Age 21 and Older

Pay to (Group) NPI:		Pay to (Group) Name:	
Taxonomy Code:		Contact Email:	
Treating/Rendering NPI:		Treating/Rendering Name:	
Client ID:	Client Name:		Client Age/DOB:
Request Year:	Begin Date:	End Date:	Frequency:

Services Type (check box): Behavioral Health ☐ Chiropractic Services ☐ Dietician Services ☐

Occupational Therapy ☐ Office Visits ☐ Physical Therapy ☐ Speech Therapy ☐

Date of Onset Condition:	Diagnosis code (up to 4):
Ordering Provider Name & NPI (required for Speech, Occupational or Physical Therapy):	

Describe injury, illness, surgery or triggering event that initiated the need for services:

Describe acute condition requiring **rehabilitative or medically necessary services**. Include progress to date to include treatment methods, goals and progress, and dates of treatment (For Behavioral Health services, you must attach the last 5 Progress Reports and treatment plan):

Describe anticipated rehabilitative progress and length of additional treatment (For Physical, Occupational, or Speech therapy services, you must attach a copy of the practitioner's order):

In signing this document you are attesting that this form was completed to the best of your knowledge and belief, that all information and data in the Authorization of Medical Necessity are true, accurate and complete, and contains no false or erroneous information.

Treating Provider Signature:_____Date_____