Wyoming Department of Health

REQUEST FOR APPEAL

Request Date: _____

Information for Appeal

Provider Information

Provider Name: _____

Provider NPI: _____

Client Information

Client Name: _____

Client ID (10 digit): _____

Client Date of Birth: _____

Claim Information

TCN(s): _____

Date(s) of Service: _____

Reason For Appeal

Policy Decisions

☐ Code Change

-Procedure Code	Code _____	Add ☐	Change ☐
-Diagnosis Code	Code _____	Add ☐	Change ☐
-NDC	Code _____	Add ☐	Change ☐
-Taxonomy Add	Code _____	Taxonomy _____	

☐ Prior Authorization

☐ Policy Dispute

Payment/Criteria Dispute

☐ NCCI Denial

☐ OPPS

☐ General Complaint Not Listed (Please describe below)

☐ Timely Filing

☐ Not Billing TPL

☐ Payment Dispute

_____

_____

_____

_____

This form and all supporting documentation should be sent using one of the following methods. Form should be filled out completely to prevent the request being returned unanswered.

MAIL: Wyoming Medicaid
ATTN: APPEALS
PO Box 667,
Cheyenne, WY 82001

EMAIL: WYCUSTOMERSVC@conduent.com
OR WYMEDPOL@conduent.com

FAX: 307.772.8405