Wyoming Department of Health

Medicaid Client Primary Dental Insurance Attestation Form

☐ New ☐ Change

Client Information	
1. CLIENT NAME:	2. CLIENT MEDICAID ID NUMBER:
3. CLIENT DOB:	4. CLIENT SSN:

5. Other Dental Insurance Coverage: ☐ Yes ☐ No*
* If no, continue to Provider Information.

6. Orthodontic Services Covered: ☐ Yes ☐ No

Insurance Information	
7. INSURANCE COMPANY NAME:	11. GROUP NUMBER:
	12. START DATE (MM/DD/YY):
8. INSURANCE COMPANY ADDRESS:	13. END DATE (MM/DD/YY):
	14. ORTHO BENEFITS:
9. POLICY HOLDER:	
10. POLICY NUMBER:	

15. POLICY HOLDER RELATIONSHIP TO CLIENT:

☐ Self ☐ Absent Parent ☐ Other ☐ Parent
☐ Spouse ☐ Brother/Sister ☐ Uncle/Aunt ☐ Grandparent
☐ Legal Guardian

Provider Information	
16. NAME:	17. NPI:
18. COMPLETED BY:	19. DATE SUBMITTED:

Include with all SMP Prior Authorization requests

FISCAL AGENT USE ONLY

MEDICAL POLICY INPUT BY: _____ DATE: _____

TPL VERIFIED BY: _____ DATE: _____

TPL INPUT BY: _____ DATE: _____

V 01/2021

Instructions for completing the Medicaid Client Primary Dental Insurance Attestation Form

Completing the Medicaid Client Dental Insurance Attestation Form
***Denotes a Required Field**
****Denotes a Required Field if a Copy of the Insurance Card is Not Supplied**
**NOTE: ***Is this new primary insurance information or a change to previously reported information?

Field Number	Title	Action
1*	**Client Name**	**Enter Last Name, First Name and Middle Initial exactly as it appears on the Medicaid ID card**
2*	**Medicaid ID Number**	**Enter the client's ten-digit Medicaid ID Number**
3*	**Client Date of Birth**	**Enter MMDDYY of client's DOB**
4*	**Patient SSN**	**Enter the client's complete Social Security Number**
5*	**Other Dental Insurance Coverage**	**Indicate if the Client has other dental insurance coverage. *If No, skip fields 6-15.***
6*	**Orthodontic Services Covered**	***If answer to field 5 is Yes*** **, indicate if the insurance policy covers ortho services. *If No*** **, skip field 14.**
7**	Insurance Company Name	Enter the Insurance Company Name as it appears on the card
8**	Insurance Company Address	Enter the Insurance Company Address as it appears on the card
9**	Policy Holder	Enter the name of the policy holder as it appears on the card
10**	Policy Number	Enter the policy number as it appears on the card
11**	Group Number	Enter the group number as it appears on the card
12**	Start Date	Enter the policy start date
13**	End Date	Enter the policy end date
14*	**Ortho Benefits**	***If the answer to field 6 was Yes,*** **list the orthodontic benefits covered by the policy.**
15*	**Policy Holder Relationship to Client**	**Please indicate the policy holder's relationship to the Medicaid client.**
16*	**[Provider] Name**	**Enter the Provider Name the form is being submitted on behalf of. This can be either the pay-to provider, or the treating provider.**
17*	**[Provider] NPI**	**Enter the Provider NPI matching the Provider Name.**
18*	**Completed By**	**Enter the name of the person filling out the form**
19*	**Date Submitted**	**Enter the date the form is being filled out**

Please do not write any additional information below the "FISCAL AGENT USE ONLY" line