Instructions for completing the Authorization of Medical Necessity Request Form

*denotes required field

Box #	Field	Action
*1	Pay to (Group) NPI:	Include the 10 digit PAY TO Group NPI number. This is the provider who will bill for services.
*2	Pay to (Group) Name:	Include the PAY TO Group provider name that matches the PAY TO Group NPI.
*3	Service Type (Select one):	Select the ONE type of services that will be performed.
4	Taxonomy Code:	Enter the 10 alpha numberic taxonomy of the PAY TO Group provider.
5	Contact Email:	Enter the email of the person to contact with questions related to this request.
*6	Treating/Rendering NPI:	Include the 10 digit treating or rendering provider NPI here. This is the provider who will be completing the services indicated in this request.
*7	Treating/Rendering Name:	Enter the treating or rendering providers name that matched the treating or rendering NPI.
*8	Client ID:	Enter the 10 digit Wyoming Medicaid ID. All digits need to be included before request will be considered.
*9	Client Name:	Enter the name of the client that matched the client ID to include at least first and last name.
*10	Frequency:	Enter the number of time the services are being requested for the remaining portion on the year.
*11	Request Year:	Enter the calendar year that the services will be provided (e.g. 2019).
*12	Begin Date:	Enter the first date of services that the services will be provided above the allowed threshold amount.
*13	ICD-10 Diagnosis Code(s) up to 4:	Enter up to 4 ICD 10 diagnosis codes that relate to the reason for the request.
*14	End Date:	Enter the last date of service that the services will be requested for the client.
*15	Date of Condition Onset:	Enter the date that the condition for which the request is related began for the client. Approximations are allowed within reason.
*16a	Describe injury, illness, surgery or triggering event that initiated the need for service:	Complete with the cause of the acute condition (i.e. post-surgery, personal injury, auto accident, ect.)
*16b	Describe medically necessary rehabilitative service. Include progress to date to include treatment methods, goals, level of improvement, and dates of treatment:	A detailed explanation as to the diagnosis and need for the services. Indicate why the client has exceeded their threshold limit.
*16c	Describe anticipated length of additional treatment:	Describe the anticipated progress and length needed ofr the additional treatment.
*17	Treating Provider signature:	The provider who is requesting the services must sign the form attesting to validity of request. Stamped, copied, and typed signatures will not be accepted.
*18	Signature Date:	The provider who is requesting the services must date the signature applied.

Mail, FAX or email the form and any supporting documentation to any of the following:

FAX: 307-772-8405 ATTN: Medical Policy

WYMedPol@conduent.com

Wyoming Medicaid
ATTN: Medical Policy,
PO Box 667,
Cheyenne, WY 82003

Wyoming Department of Health

Authorization of Medical Necessity

1) Pay to (Group) NPI:	**2) Pay to (Group) Name:**	**3) Service Type (Select one):**
4) Taxonomy Code:	**5) Contact Email:**	☐ **Chiropractic Services**
6) Treating/Rendering NPI:	**7) Treating/Rendering Name:**	☐ **Dietician Services**
8) Client ID:	**9) Client Name:**	**10) Frequency:** **# visits** _____ *per* ☐ **Week** ☐ **Month**
11) Request Year:	**12) Begin Date:**	
13) ICD-10 Diagnosis Code(s) up to 4: 1)_____ 2)_____ 3)_____ 4)_____	**14) End Date:**	**15) Date of Condition Onset:**

16a) Describe injury, illness, surgery or triggering event that initiated the need for service:

16b) Describe need for medically necessary service. Include progress to date to include treatment methods, goals, level of improvement, and dates of treatment:

16c) Describe anticipated length of additional treatment:

In signing and dating 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.

17) TREATING Provider Signature:_____

18) Date:_____

FISCAL AGENT USE ONLY

Submit form to ATTN Medical Policy:

MAIL: Wyoming Medicaid, PO Box 667, Cheyenne, WY 82003 | FAX: 307-772-8405 | EMAIL: WYMedPol@conduent.com