



[Date]

Wyoming Medicaid,

This letter is to request the submission of the attached claim for payment. As of this date, we have made two attempts within ninety days of service to gain payment for the services rendered from the primary insurance with no resolution. We are now requesting payment in full from Medicaid. Please find all relevant and required documentation attached.

Thank you.

Sincerely,

Authorized Representative of \_\_\_\_\_ (Billing Facility)

Name of Insurance Company billed: \_\_\_\_\_

Date billing attempts made: \_\_\_\_\_

Policyholder's name: \_\_\_\_\_

Policyholder's policy number: \_\_\_\_\_

Comments: \_\_\_\_\_

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