Wyoming Department of Health

SEVERE MALOCCLUSION PROGRAM - REFERRAL
CLIENTS LESS THAN 12 YEARS OF AGE

I would like to refer_____ for an
(Name of client)

orthodontic examination to_____.
(Name of orthodontist)

Pay-to Provider NPI:_____ Treating Providers NPI: _____

Client Date of Birth:_____/_____/ 20_____ Client Medicaid ID: _____
Month Day Year

Parent/Legal Guardian: _____

Address, City, Zip: _____

Phone: (_____)_____-_____

Dentist's Reason for Ref. (must contain medically necessary reason to evaluate before the age of 12):

Dentist's Signature: _____

Dentist's Name (Printed): _____

Address: _____
(Street/P.O. Box, City, State, Zip Code)

Telephone:_____ Date:_____

NPI:_____ Provider ID:_____

Send completed referral to:

Wyoming Medicaid
Attn: Dental Services
PO Box 667
Cheyenne, WY 82003-0067
wydental@conduent.com

Version 01/2021