Wyoming Department of Health

Division of Healthcare Financing
Wyoming Medicaid
122 West 25th St., 4th Floor West
Cheyenne, WY 82002
Phone (307) 777-7531 • 1-866-571-0944
Fax (307) 777-6964 • www.health.wyo.gov

Swing Bed
Exemption Letter

Facility Name:_____certifies that Medicare or other third party liability has been billed for this Wyoming Medicaid client.

To receive payment from Wyoming Medicaid without an EOMB from the third party one or more of the following situations must be met and this letter must accompany a 18X UB-04 claim:

(Check one box)

1. ☐	The client did not complete a 3 day hospital stay and is therefore not eligible for Medicare benefits. The hospital stay dates were ___/___/_____ to ___/___/_____. This must be reviewed if the patient returns to the hospital after any nursing facility stay, and for interim, continuing claims.
2. ☐	This client has exhausted the Medicare and/or other insurance benefit period. The date of the Medicare and/or other insurance benefits period was/is ___/___/_____ to ___/___/_____.
3. ☐	This client did complete a 3 day hospital stay. Medicare was billed for _____ days and an EOMB for that period was previously submitted. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached for succeeding claims.
4. ☐	Medicare and/or other insurance denied payment of the swing-bed benefit. A copy of the EOMB is attached. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached to succeeding claims.

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature _____ Title _____ Date _____