Third Party Resources Information Sheet

NEW CHANGE

CLIENT NAME:	CLIENT MEDICAID ID NUMBER:
CLINENT DOB:	CLIENT SSN:
INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:
TYPE OF COVERAGE: Major Medical Physician Hospital Prescription Drugs Surgical Other	POLICY HOLDER
START DATE (MM/DD/YY):	END DATE (MM/DD/YY):
POLICY NUMBER:	GROUP NUMBER:
RELATIONSHIP OF CLIENT TO CASE HEAD: Self(1) Absent Parent(2) Other(3) Parent(4) Spouse(5) Brother/Sister(6) Uncle/Aunt(7) Grandparent(8) Legal Guardian(9)	
NAME OF PROVIDER:	
COMPLETED BY:	DATE SUBMITTED:

RETURN TO:
WYOMING MEDICIAD
PO BOX 667
CHEYENNE, WY 82003
FAX (307) 772-8405

FISCAL AGENT USE ONLY

AUTHORIZED BY:________________________________ DATE:_________________________

INPUT BY:______________________________________ DATE:_________________________