Wyoming Medicaid Clearinghouse Authorization Form

Complete one form for each pay-to provider. Do not complete this form for treating or rendering providers.

Note: Only pay-to/group providers need to be authorized, treating/rendering providers do not.

Provider Name	
NPI or Provider Number	
Tax – ID	
Physical Address	
City, State, Zip Code	
Telephone Number	
Fax Number	
Email Address	
Contact Name	
Contact Phone Number	
Contact Email	

Mark which transactions the clearinghouse is authorized to send/receive on your behalf:

X	X12N 5010 999 Implementation Acknowledgement (required)	X	X12N 5010 277CA Claim Acknowledgement (required)
	X12N 5010 276/277 Health Care Claim Status Request and Response		X12N 5010 270/271 Health Care Eligibility Benefit Inquiry and Response
	X12N 5010 278 Health Care Services – Request for Review and Response; Health Care Services Notification and Acknowledgement (Prior Authorizations)		X12N 5010 837 Health Care Claim (Professional, Institutional, and Dental)
	X12N 5010 835 Health Care Claim Payment/Advice (Remittance Advice)		

I, _____, representative of the provider above
Provider/Provider's Representative

_____, authorize the clearinghouse _____
Name of Provider Clearinghouse Name

TPID _____ to submit/accept the above transactions on my behalf.
Trading Partner ID

_____ _____
Provider / Provider Representative Signature Date

Please return to:
Wyoming Medicaid
Attn: EDI Services
PO Box 667
Cheyenne, WY 82003-0667