# WYOMING DEPARTMENT OF HEALTH TB PROGRAM

### PRIOR AUTHORIZATION REQUEST FORM

### THIS FORM MUST BE FILLED OUT PRIOR TO PATIENT RECEIVING SERVICES

#### PLEASE GIVE TO PATIENT TO TAKE WITH THEM AND PRESENT TO STAFF AT TIME OF APPOINTMENT

# CHEST X-RAYS, LIVER FUNCTION TESTS AND IGRA'S WILL ONLY BE PAID AT THE CURRENT MEDICAID RATES OR THE ACTUAL BILLED FEE WHICHEVER IS LESS:

СРТ	Name	Critical Access (CA)	General (GEN)	Children's (CH)	Practioner (PP)	Wyoming Public Health Lab
71010	X-Ray Single	\$83.02	\$32.63	\$70.36	\$11.65	n/a
71020	X-Ray Double	\$83.02	\$32.63	\$70.36	\$15.76	n/a
36415	Venipuncture	\$2.70	\$2.70	\$2.70	\$2.70	n/a
80076	Liver Function Panel	\$9.67	\$9.67	\$9.67	\$9.67	n/a
71010.26	Single-Rad. Fee	n/a	n/a	n/a	\$6.51	n/a
71020.26	Double-Rad. Fee	n/a	n/a	n/a	\$7.88	n/a
86480, 86481	IGRA-	\$77.93	\$77.93	\$77.93	\$77.93	\$40.00

Today's Date:		Proposed Date of Service:				
Patient First Name:		Facility Name:				
Patient Last Name:			-			
Contact Person:			Ordering Provider:			
Phone:	Fax:					
Chest X-ray	Interferon Ga	mma Release	☐ Liver Function Test	Other:		
☐ One-view (Single)	Assay (IGRA)  WPHL  Other					
☐ Two View (Double)						
	Pl		Insurance Claim form for pay	vment to:		
			oming WDH TB Program ellowstone Road, Suite 510			
			heyenne, WY 82002			
	******		OFFICE USE ONLY *****	*******		
☐ Request Approved Prior Authorization Num ☐ Request Denied Signature:		Authorization Num	nber:			
		Date:				
Reason for denial:	<b>I</b>					

Wyoming Department of Health • Public Health Division Preventive Health and Safety Section • TB Program