

**WYOMING DEPARTMENT OF HEALTH
COMMUNICABLE DISEASE UNIT PRIOR AUTHORIZATION REQUEST FORM**

1. This form must be filled out, submitted to WDH and authorized by program staff prior to the patient receiving services.
2. Prior authorization approvals or denials will be processed within 48-72 business hours. Please plan services to be received accordingly.
3. Please provide an authorized form to the patient to take with them and present to radiology or laboratory staff at the time of service.

Chest x-rays, liver function tests, and IGRAs will only be paid at the current Medicaid rate or the actual billed fee, whichever is less:

CPT	Name	Critical Access (CA)	General (GA)	Children's (CH)	Practitioner (PP)	WY Public Health Lab
71010	X-Ray Single	\$89.59	\$33.89	\$74.21	\$11.65	
71020	X-Ray Double	\$89.59	\$33.89	\$74.21	\$15.76	
36415	Venipuncture	\$2.70	\$2.70	\$2.70	\$2.70	
80076	Liver Function Panel	\$9.67	\$9.67	\$9.67	\$9.67	
71010.26	Single-Rad. Fee	\$6.51	\$6.51	\$6.51	\$6.51	
71020.26	Double-Rad. Fee	\$7.88	\$7.88	\$7.88	\$7.88	
86480	IGRA	\$77.93	\$77.93	\$77.93	\$77.93	\$40.00

Today's Date:		Proposed Date of Service:	
Patient First Name:		Patient Last Name:	Patient DOB:
Facility Requesting Service:		Ordering Provider:	Facility Contact Person:
Facility Phone:		Facility Fax:	Contact Person's E-mail

Services Requested		
Chest X-Ray (select one) <input type="checkbox"/> One-view (single) <input type="checkbox"/> Two-view (double)	<input type="checkbox"/> Liver Function Panel	IGRA (denote lab below) <input type="checkbox"/> WPHL <input type="checkbox"/> Other: _____

Services are provided for highest risk individuals. Please indicate risks below:			
<input type="checkbox"/> Foreign born Country _____	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Contact to infectious TB patient	<input type="checkbox"/> Other, please indicate _____
Please indicate client's health insurance status:			
<input type="checkbox"/> Insured	<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> Underinsured	<input type="checkbox"/> Uninsured

Please submit prior authorizations by fax to 307-777-5279.

INTERNAL USE ONLY

____ Request Approved	Authorization #: _____		
____ Request Denied	Reason: _____		
Program Signature/Date: _____			

Claims for payment must be submitted on health insurance claim forms (HICF) to:
Wyoming Department of Health, TB Program
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
Phone: 307-777-3562 Fax: 307-777-5279
Claims must be submitted by the end of the calendar year following the date of service.