COMMUNICABLE DISEASE TREATMENT PROGRAM
Prior Authorization Request Form
PLEASE ATTACH WRITTEN ESTIMATE WITH TREATMENT PLAN

Today's Date:	Proposed Date of Service:
Soundex Number:	Company Name & Address:
Case Manager: Phone: Fax:	Phone: Fax:

☐ Medical Care	☐ Dental Care	☐ Vision Care	☐ Mental Health	☐ Substance Abuse
☐ Diagnostics/Lab	☐ Meals/Nutrition	☐ Supportive Services:		

Transportation:
- ☐ Reason for appointment:_____
  - ☐ Bus pass/tokens; ☐ Taxi; ☐ Other_____
  - ☐ Third Party Driver – please provide the name of person or business providing transportation in the description area of this form.

☐ Other:

BRIEFLY DESCRIBE THIS REQUEST:

Estimated Cost of Services:

Communicable Disease Treatment Program agreed contribution: ***Comments:***

$_____
Please send Health Insurance Claim form for payment to:
Wyoming Communicable Disease Treatment Program
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
307-777-5800/307-777-7382

********** OFFICE USE ONLY **********

☐ Request Approved HIV Services Program	Signature: Date: PA#
EXPIRATION DATE:	
☐ Request Denied HIV Services Program	Reason

Justification for denial or additional information:_____

_____

_____

Revised 1/2017