

# Qualified Provider/ Qualified Hospital Application

This is an application to become a Qualified Provider or Qualified Hospital in order to determine Presumptive Eligibility. Each staff member requesting to process Presumptive Eligibility applications will need to complete this application. Please complete and email or fax this application to the Medicaid Eligibility Unit at: [eceligibilityunit@wyo.gov](mailto:eceligibilityunit@wyo.gov) or 307-777-7085.

Questions about this application or the Presumptive Eligibility program should be directed to the Medicaid Eligibility Unit at: 307-777-3423.

## PART I– Type of Organization

Check one:

- Public Health Nursing Office
- Federally Qualified Health Center
- Women's Resource Center
- Medicaid Provider
- Indian Health Service
- Hospital

## PART II– Demographics

|                                 |       |
|---------------------------------|-------|
| Applicant Name                  | _____ |
| Applicant Title                 | _____ |
| Applicant Work Number           | _____ |
| FAX Number                      | _____ |
| Applicant Email Address         | _____ |
|                                 |       |
| Clinic/Facility Name            | _____ |
| Clinic/Facility Address         | _____ |
| Clinic/Facility Mailing Address | _____ |
| City/ State/ Zip                | _____ |
|                                 |       |
| Clinic/Facility Contact Person  | _____ |
| Title                           | _____ |
| Contact Person Number           | _____ |
| Contact Person Email            | _____ |

**\*\*You will receive an email from the Wyoming Department of Health with instructions on how to sign up for required training prior to becoming an approved Qualified Provider or Qualified Hospital.**