COMMUNICABLE DISEASE UNIT – PRIOR AUTHORIZATION FORM

Submit prior authorizations by fax to 307-777-7382

Today's date:	Proposed date of service:	
Facility requesting service:	Case Manager:	Phone: Fax:

TREATMENT SERVICES PROGRAM		
Soundex number:	Provider/Company Name:	Phone:
☐ Medical care	☐ Dental care	☐ Vision care/glasses
☐ Mental health	☐ Substance abuse	☐ Lab/other diagnositics
☐ Meals/Nutrition	☐ Supportive services	☐ Other
Attach provider estimate for services and describe request:		
☐ Transportation ☐ Bus pass/tokens ☐ Taxi ☐ Other _____ ☐ Third Party Driver, person/company providing service _____		

TB PROGRAM		
Patient Name:	Patient DOB:	Ordering Provider:
Services Requested		
☐ Chest X-Ray (single) ☐ Liver Function Panel ☐ IGRA ☐ Chest X-Ray (double)		
Please indicate high-risk category:		
☐ Foreign born ☐ HIV positive ☐ Contact to infectious TB patient Country:		
Insurance status:		
☐ Insured ☐ Medicare/Medicaid ☐ Uninsured ☐ Underinsured		
Claims must be submitted by the end of the calendar year following the date of service.		

Claims for payment must be submitted on health insurance claim forms (HICF) to:
Wyoming Department of Health, Communicable Disease Unit
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002

☐ Request Approved	Authorization #	Expiration date:
☐ Request Denied, Reason:		
Approved amount $		
Program signature and date		