

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:
<input type="checkbox"/> Medical care	<input type="checkbox"/> Dental care	<input type="checkbox"/> Vision care/glasses
<input type="checkbox"/> Mental health	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Lab/other diagnostics
<input type="checkbox"/> Meals/Nutrition	<input type="checkbox"/> Supportive services	<input type="checkbox"/> Other
Attach provider estimate for services and describe request:		
<input type="checkbox"/> Transportation <input type="checkbox"/> Bus pass/tokens <input type="checkbox"/> Taxi <input type="checkbox"/> Other _____ <input type="checkbox"/> Third Party Driver, person/company providing service _____		

TB PROGRAM		
Patient Name:	Patient DOB:	Ordering Provider:
Services Requested		
<input type="checkbox"/> Chest X-Ray (single)	<input type="checkbox"/> Liver Function Panel	<input type="checkbox"/> IGRA
<input type="checkbox"/> Chest X-Ray (double)		
Please indicate high-risk category:		
<input type="checkbox"/> Foreign born	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Contact to infectious TB patient
Country:		
Insurance status:		
<input type="checkbox"/> Insured	<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> Uninsured <input type="checkbox"/> 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
 122 W. 25th St., West Herschler, Suite 301
 Cheyenne, WY 82002**

<input type="checkbox"/> Request Approved	Authorization #	Expiration date:
<input type="checkbox"/> Request Denied, Reason:		
Approved amount \$		
Program signature and date		