

**COMMUNICABLE DISEASE UNIT – PRIOR AUTHORIZATION FORM**

**Submit prior authorizations via email at [cdu.treatment@wyo.gov](mailto:cdu.treatment@wyo.gov) or fax to 307-777-7382.**

Today's date:		Proposed date of service:	
Facility requesting service:		Case Manager:	Phone: Fax:
Provider/Company Name:		Phone:	Fax:
<b>TREATMENT PROGRAM SERVICES</b>			
Soundex number:			
<b>Service Requested (please select from below)</b>			
Medical care	Dental care	Vision care/glasses	
Mental health	Substance abuse	Lab/other diagnostics	
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 _____			
<b>TUBERCULOSIS TESTING</b>			
Patient Name:		Patient DOB:	
Insurance Status:	Insured                      Uninsured	Medicare/Medicaid	VA
<b>Services Requested</b>	<input type="checkbox"/> Chest X-Ray <input type="checkbox"/> IGRA	<input type="checkbox"/> Liver Function Panel	<input type="checkbox"/> Sputum
<b>High Risk Factor (select all that apply)</b>			
<input type="checkbox"/> Contact to infectious TB patient <input type="checkbox"/> HIV positive <input type="checkbox"/> Positive TST or IGRA <input type="checkbox"/> Foreign born, specify Country of Origin:			
<b>KIDNEY FUNCTION TESTING</b>			
Patient Name:		Patient DOB:	
Insurance Status:	Insured                      Uninsured	Medicare/Medicaid	VA
Testing Requested	Specify Test:		

**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**

<b>Claims must be submitted by expiration date noted below to ensure payment.</b>		
<input type="checkbox"/> Request Approved	Authorization #	Expiration date:
<input type="checkbox"/> Request Denied, Reason:		
Approved amount	Approval	
\$	Comments:	
Program signature and date		

## **Communicable Disease Unit - Prior Authorization Provider Billing Instructions**

The Wyoming Communicable Disease Unit (CDU) follows a direct fee for service model for provider reimbursement. A client may seek services at any provider across the State of Wyoming.

All Treatment Program services **must be prior authorized and require a written cost estimate**. Providers must also accept Wyoming Medicaid. In some cases a letter of medical necessity may need to be provided.

### **Billing Instructions**

The CDU is payor of last resort, all primary billing must be processed before the Program can proceed with payment. Primary billers include, but are not limited to, private or marketplace insurance, Medicare, and Medicaid.

CDU prefers provider billing offices submit claims on a health insurance claim form (HICF/UB-04/Form1500). An in-house invoice is also acceptable as long as the listed documentation is provided:

- Date of Service
- Service Location
- Provider Name & Address
- Diagnosis Codes
- Procedure Codes

The program requires this listed documentation in order to process payment. Claims processing may be delayed if any of the above documentation is missing.

**Please send complete bill including the detailed billing and the primary insurance EOB to:**

- Wyoming Department of Health, Communicable Disease Unit
- 122 W. 25th St., 3rd Floor West
- Cheyenne, WY 82002

Claims may also be confidentially faxed to the Program at 307-777-7382 or emailed to [cdu.treatment@wyo.gov](mailto:cdu.treatment@wyo.gov)