

COMMUNICABLE DISEASE UNIT – PRIOR AUTHORIZATION FORM
 Submit prior authorizations via email at cdu.treatment@wyo.gov or fax to 307-777-7382.

Today's date:		Proposed date of service:	
Facility requesting service:		Phone:	Fax:
Provider/Company Name:		Phone:	Fax:
Insurance Status: <input type="checkbox"/> Uninsured <input type="checkbox"/> Insured, list carrier for service requested (i.e. Delta Dental, BCBS, Medicaid etc.) _____			
TREATMENT PROGRAM SERVICES			
Soundex number:			
Service Requested (please select from below)			
<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 use	<input type="checkbox"/> Lab/other diagnostics	
<input type="checkbox"/> Meals/Nutrition	<input type="checkbox"/> Supportive services	<input type="checkbox"/> Other (specify):	
Attach provider estimate for services and describe request: 			
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: _____			
TUBERCULOSIS TESTING			
Patient Name:		Patient DOB:	
Service(s) Requested: <input type="checkbox"/> Chest X-rays <input type="checkbox"/> IGRA <input type="checkbox"/> Sputum <input type="checkbox"/> Office Visit <input type="checkbox"/> Liver Function Panel, specify number of draws: _____			
High Risk Factor (select all that apply) <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: _____			
PrEP KIDNEY FUNCTION TESTING			
Patient Name:		Patient DOB:	
Specify Testing Requested:			

Claims must be submitted to client's primary insurance prior to payment from the Communicable Disease Unit. Remaining amount due must be submitted on a health insurance claim form (HICF) to:
Wyoming Department of Health, Communicable Disease Unit
122 W. 25th St., 3rd Floor West Cheyenne, WY 82002

Claims must be submitted by expiration date noted below to ensure payment.		
<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. Providers must bill any primary insurance a client has prior to billing CDU. Balance billing patient's for services prior authorized at the approved amount is not allowable.

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 be required.

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