Completing the Attachment Cover Sheet

An asterisk (*) denotes a required field.

Complete all applicable fields.

Title	Action
Pay to Provider Name*	Enter the name of the Pay to (Group) Provider.
Pay to NPI*	Enter the 10-digit NPI or Provider Number for the Pay to (Group) Provider.
Member Name*	Enter the Member's full name.
Medicaid ID*	Enter the Member's 10-digit Wyoming Medicaid ID number.
Claim From Date of Service*	Enter the first date of service on the claim in mm/dd/yyyy format.
Claim To Date of Service*	Enter the last date of service on the claim in mm/dd/yyyy format.
Transaction Control Number (TCN)*	Enter the 17-digit Transaction Control Number (TCN) for the electronic claim
Attachment Type*	Select the attachment type that was indicated on the electronic claim.

This cover sheet can be uploaded electronically via the Web Portal.

Return the completed cover sheet with attachments to:

Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547

Wyoming Department of Health

Attachment Cover Sheet

Use this cover sheet when electronically submitting a claim that requires attachments. The supporting documents (for example, EOB or medical records) must be attached to this cover sheet. If documents are received without this cover sheet, then the request **CANNOT** be processed, and the documents will be shredded.

- All information entered on this cover sheet must match the data entered in the 837 claim transaction exactly, including the Attachment Type.
- The Attachment Transmission Code in the 837 claim transaction must be set to 'BM' (By Mail) to indicate the attachment is being sent separately.

Pay to Provider Name ______________________ **Pay-To NPI/ Provider Number** ______________

Member Name ______________________ **Member ID** ______________

Claim From Date of Service __________ **Claim To Date of Service** __________ **Transaction Control Number (TCN)** ______________

Attachment Type

AS: Admission Summary	MT: Models
B2: Prescription	NN: Nursing Notes
B3: Physician Order	OB: Operative Notes
B4: Referral Order	OZ: Support Date for Claim
CT: Certification	PN: Physical Therapy Notes
CK: Consent Form(s)	PO: Prosthetics or Orthotic Certification
DA: Dental Models	PZ: Physical Therapy Certification
DG: Diagnostic Report	RB: Radiology Films
DS: Discharge Summary	RR: Radiology Reports
EB: Explanation of Benefits	RT: Report of Tests and Analysis Report

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Any Questions, call 1-888-996-6223

WYBMS-Attachment Coversheet