Wyoming Department of Health

Documentation of Medical Necessity Form

Complete all applicable fields.

MEMBER INFORMATION

1. Date of Birth	2. Sex ☐ M ☐ F	3. Age	4. Member ID
5. Member Name (Last, First, MI)			6. Member Telephone
7. Member Street Address		8. City	State Zip Code

PROVIDER INFORMATION

9. NPI/Provider Number	10. Provider Telephone	11. Provider Name
12. Provider Street Address	City	State Zip Code

SERVICE INFORMATION

13. **Summary of History** *(Physical Examination, Laboratory, X-Ray Studies, Prescriptions, and other applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.)*

14. **Date(s) of Service**

15. **If this service was performed out-of-state, please provide a brief justification statement.**

16. **To the best of my knowledge, the above information is true, accurate, and complete, and the requested services are medically indicated and necessary to the health of the Member.**

Signature of Physician or Provider _____ **Date** _____

APPROVAL (FOR AGENCY USE ONLY)

17. Comments/Explanation

Approved ☐ Yes ☐ No Date _____ Signature _____

Note: Approval does not guarantee payment. Payment is subject to Member's eligibility and Wyoming benefit limitations. Be sure the identification card is current before rendering service.

Mail completed form to:
Wyoming Medicaid Fiscal Agent
P.O. Box 547
Cheyenne, WY 82003-0547