Wyoming Department of Health

Request for Appeal Form

Request Date: _____

Information for Appeal

Provider Information

Provider Name _____ NPI/Provider Number _____

Member Information

Member Name _____ Member ID (10-digit) _____

Member Date of Birth _____

Claim Information

Transaction Control Numbers (TCNs) _____ Date(s) of Service _____

Reason for Appeal

Policy Decisions

☐ Code Change

-Procedure Code Code _____ ☐ Add ☐ Change

-Diagnosis Code Code _____ ☐ Add ☐ Change

-NDC Code _____ ☐ Add ☐ Change

-Taxonomy Add Code _____ Taxonomy _____

☐ Prior Authorization

☐ Policy Dispute

Payment/Criteria Dispute

☐ NCCI Denial

☐ OPPS

☐ DRG

☐ General Complaint Not Listed (please describe below)

☐ Timely Filing

☐ Not Billing TPL

☐ Payment Dispute

This form and all supporting documentation should be sent using one of the following methods. Fill out the form completely to prevent the request being returned unanswered.

Mail completed form to:
Wyoming Medicaid
ATTN: Appeals
PO Box 1248
Cheyenne, WY 82003-1248

Email:
WYappeals@cns-inc.com

Fax:
(307) 460-7408

WYBMS-Grievance and Appeal