Wyoming Department of Health

Medicaid Member Death Report Form

Pursuant to Wyoming Department of Health, Division of Healthcare Financing (Wyoming Medicaid) rules, Providers are required to notify the Department of Health, Division of Healthcare Financing of the death of any Wyoming Medicaid Member in their facility within three (3) working days of the Member's death.

Member Information

Member Name _____ **Member ID** _____

Member Address
(Prior to entering nursing home.)
_____
Street Address City State Zip Code

Social Security Number _____ **Date of Birth** _____

Marital Status _____ **Date of Death** _____

Guardian, Next of Kin, or Power of Attorney Information

Contact Name _____ **Contact Number** _____

Contact Address
_____
Street Address City State Zip Code

Provider Information

Provider Name _____ **Contact Number** _____

Provider Address
_____
Street Address City State Zip Code

Person Completing Form

Name of Person Completing Form _____ **Date** _____

Please send the completed form via mail or FAX it promptly to the address below.

Mail completed form to:
HMS Estate Recovery
333 W Hampden Ave.
Suite 425
Englewood, CO 80110
Phone: 1-888-996-6223 (1-888-WYO-MCAD)
Email form as an attachment: wyreferrals@gainwelltechnologies.com

WYBMS-Medicaid Member Death Report form