Wyoming Department of Health

Medicaid Member Primary Dental Insurance Attestation Form

1. ☐ New ☐ Change

MEMBER INFORMATION

2. **Member Name** _____ 3. **Member ID** _____

4. **Member DOB** _____ 5. **Member SSN** _____

6. **Other Dental Insurance Coverage** ☐ Yes ☐ No* ** If no, continue to Provider Information Section.*

7. **Orthodontic Services Covered** ☐ Yes ☐ No

INSURANCE INFORMATION

8. **Insurance Company Name** _____

9. **Group Number** _____

10. **Start Date** _____

11. **Insurance Company Address**

_____
Street Address

_____
City State Zip Code

12. **End Date** _____

13. **Ortho Benefits**

14. **Policy Holder Name** _____ 15. **Policy Number** _____

16. **Relationship to Member** ☐ Self ☐ Absent Parent ☐ Other ☐ Parent ☐ Spouse ☐ Brother/Sister ☐ Uncle/Aunt ☐ Grandparent ☐ Legal Guardian

PROVIDER INFORMATION

17. **Provider Name** _____ 18. **NPI/Provider Number** _____

19. **Name of Person Completing This Form** _____ 20. **Date Submitted** _____

Include with all Claims and the SMP Prior Authorization requests

HMS Third Party Referral (TPR)
5615 High Point Drive
Irving, TX 75038
Phone: 1-888-996-6223 (1-888-WYO-MCAD)
Email form as an attachment: WYTPR@hms.com

WYBMS-Non Medicaid Member Primary Dental Insurance Attestation

Wyoming Department of Health

Completing the Medicaid Member Primary Dental Insurance Attestation Form

An asterisk (*) denotes a required field.

A double asterisk (**) denotes a required field if a copy of the insurance card is not supplied.

Complete all applicable fields.

Field Number	Title	Action
1*	**New/Change**	**Select the checkbox to identify this as new primary insurance information or a change to previously reported information.**
2*	**Member Name**	**Enter the Member's full name exactly as it appears on the Medicaid ID card.**
3*	**Medicaid ID Number**	**Enter the Member's ten-digit Medicaid ID Number**
4*	**Member Date of Birth**	**Enter MMDDYY of Member's DOB**
5*	**Patient SSN**	**Enter the Member's complete Social Security Number**
6*	**Other Dental Insurance Coverage**	**Indicate if the Member has other dental insurance coverage. *If No, skip fields 7-16.***
7*	**Orthodontic Services Covered**	***If answer to field 6 is Yes*, indicate if the insurance policy covers ortho services. *If No*, skip field 13.**
8**	Insurance Company Name	Enter the Insurance Company Name as it appears on the card
9**	Insurance Company Address	Enter the Insurance Company Address as it appears on the card
10**	Policy Holder	Enter the name of the policy holder as it appears on the card
11**	Policy Number	Enter the policy number as it appears on the card
12**	Group Number	Enter the group number as it appears on the card
13**	Start Date	Enter the policy start date
14**	End Date	Enter the policy end date
15*	**Ortho Benefits**	***If the answer to field 6 was Yes*, list the orthodontic benefits covered by the policy.**
16*	**Policy Holder Relationship to Member**	**Please indicate the policy holder's relationship to the Medicaid Member.**
17*	**Provider Name**	**Enter the Provider Name the form is being submitted on behalf of. This can be either the pay-to provider, or the treating provider.**
18*	**NPI/ Provider Number**	**Enter the Provider NPI matching the Provider Name.**
19*	**Completed By**	**Enter the name of the person filling out the form**
20*	**Date Submitted**	**Enter the date the form is being filled out**

Please do not write any additional information below the "FISCAL AGENT USE ONLY" line.