Wyoming Department of Health

Date _____

Wyoming Medicaid,

This letter is to request the submission of the attached claim for payment. As of this date, we have made two attempts within ninety days of service to gain payment for the services rendered from the primary insurance with no resolution. We are now requesting payment in full from Medicaid. Please find all relevant and required documentation attached.

Thank you.

Sincerely,

Authorized Representative of _____ **(Billing Facility)**

Name of Insurance Company Billed _____

Date Billing Attempts Made _____

Policyholder's Name _____

Policyholder's Policy Number _____

Comments:

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