Wyoming Department of Health

Third Party Resources Information Sheet

☐ **NEW** ☐ **CHANGE**

Member Name _____ **Member ID** _____

Member DOB _____ **Member SSN** _____

Insurance Company Name **Insurance Company Address**

Type of Coverage

- ☐ Major Medical
- ☐ Hospital
- ☐ Surgical
- ☐ Physician
- ☐ Prescription Drugs
- ☐ Other

Policy Holder

Start Date (MM/DD/YY) _____ **End Date (MM/DD/YY)** _____

Policy Number _____ **Group Number** _____

Relationship of Member to Case Head

- ☐ Self (1)
- ☐ Absent Parent (2)
- ☐ Other (3)
- ☐ Parent (4)
- ☐ Spouse (5)
- ☐ Brother/Sister (6)
- ☐ Uncle/Aunt (7)
- ☐ Grandparents (8)
- ☐ Legal Guardian (9)

Name of Provider _____

Completed By _____ **Date Submitted** _____

RETURN TO:
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

FISCAL AGENT USE ONLY

Authorized By _____ Date _____ mm/dd/yyyy

Input By _____ Date _____ mm/dd/yyyy