Wyoming State Hospital
Title 25 Certification Form

Patient Name: _____ Account #:_____
Admit Date: _____ Discharge Date: _____

Are you on Wyoming Medicaid? (circle one) YES NO

Do you have other insurance? (circle one) YES NO
If yes, name of insurance: _____

Patient: _____ Date: _____
(or authorized representative)

Witness: _____ Date: _____
(if patient or representative is unable to sign)

PROVIDER CERTIFICATION

I, the undersigned, certify that the above named patient did not have any public or private health insurance for the balance of this account and that there are no other governmental benefit programs from which this provider can recover the remainder of the costs of treatment from the patient's stay as indicated above.

_____ _____

Provider CEO/CFO signature Date

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Revised: 04/01/2017
Form Originator: Wyoming State Hospital