Mark Gordon
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
5221 Yellowstone Rd
Cheyenne, Wyoming 82009
http://www.wyomingworkforce.org

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PROVIDER REQUEST FOR PREAUTHORIZATION REVIEW

Phone: (307) 777-6307 Fax: (307) 777-8724 Email: dws-wscpreauth@wyo.gov

- ***Preauthorization of procedures is VOLUNTARY.***
- ***If the HCP determines a procedure is urgent/emergent, proceed without preauthorization.***

Date: _____ Date of Procedure (if scheduled)_____

Claimant Name:_____ Claim Number: _____

Date of Birth:_____ Date of Injury: _____

Requesting Physician: _____ Tax ID#:_____

Physician Phone:_____ Physician Fax: _____

Physician Contact Person: _____ Contact Person email:_____

Diagnosis: _____

ICD-10 - CM Diagnosis Code(s): _____

CPT Code(s):_____

Procedure (include side and part of body or levels of spine)_____

_____

Related to work injury? Yes ☐ No ☐

Estimated recovery time or Return to Work_____

Comments:_____

_____

_____

Along with this form, <u>the following required criteria must be submitted</u>:

- ***Current medical note discussing proposed procedure signed by requesting physician.***
- ***Reports of diagnostic studies completed in the last 12 months.***
- ***Completed check sheet if requesting a SCS/DRG, cervical or lumbar spinal fusion, SI fusion, or artificial disc replacement.***

Treatment guidelines and check sheets are available at: http://wyomingworkforce.org

Must be completed by WCD Preauthorization Nurse

Authorized: Yes ☐ No ☐ Date:_____ Preauthorization #: _____

Authorized by: _____
Name Telephone #

Approval Valid: _____ Through:_____

Comments:_____

_____

_____

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