



Matthew H. Mead
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
<http://www.wyomingworkforce.org>



John Cox
Director
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Deputy Director

PROVIDER REQUEST FOR PREAUTHORIZATION REVIEW

Phone: (307) 777-6307

Fax: (307) 777-8724

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

Request Date: _____

Claimant Name: _____ Date of Birth: _____

Claim Number: _____ Date of Injury: _____

Requesting Physician: _____

Physician Phone: _____ Physician Fax: _____

Physician Contact Person: _____

Written Diagnosis: _____

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

CPT Code(s): _____

In the event the submitted CPT codes are unbundled, the Division will base reimbursement on the current AAOS Complete Global Service Data.

Procedure (include side of body or levels of spine): _____

Date of Procedure (if scheduled): _____

Comments: _____

Along with this form, please submit the following:

- *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, 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

Authorization Granted: Yes No Date: _____ Preauthorization #: _____

Granted by: _____

Name

Telephone #

Expected recovery timeframe: _____ days.

Comments: _____

***** Authorizations are valid for 90-calendar days from date of approval*****

