Wyoming Department of Health

Healthcare Financing Division
Wyoming Medicaid
122 West 25th Street. 4 West
Cheyenne, WY 82002
(307) 777-7531 • 866-571-0944
Fax (307) 777-6964 • www.health.wyo.gov

Stefan Johansson
Director

Mark Gordon
Governor

June 9, 2023

Re Fingerprinting – Based Criminal Background (FCBC) Check

Dear Provider:

Please follow the instructions below to become or remain a Wyoming Medicaid Provider.

The Division of Healthcare Financing, Medicaid Program, is required under 42 CFR 455.450(c), to identify providers categorized as high risk and/or persons who have a five percent or more direct or indirect ownership interest in a high risk provider type, to perform the following:

1. Submit a set of fingerprints in accordance with 42 CFR 455.434;
2. Consent to a criminal background check.

If you have been identified as either a high risk provider or having a five percent or more direct or indirect ownership interest you are required to perform the above.

Under 42 CFR 455.416, the state Medicaid agency must terminate or deny enrollment of a high risk provider type or any person with a five percent or greater direct or indirect ownership interest in a high risk provider type if the provider or person:

1. Fails to submit fingerprints within 30 days of the Medicaid agency's request;
2. Fails to submit fingerprints in the form and manner requested by the Medicaid agency; or
3. Has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or CHIP program in the last 10 years.

In all three cases, the agency may allow the provider to enroll if the agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

Fingerprints may be obtained at any local law enforcement agency or sheriff's office.

Please have your fingerprints submitted to:

Wyoming Division of Criminal Investigation
208 South College Drive
Cheyenne, WY 82007

You MUST list the following information on the Fingerprint Cards:

1. ***Under Employer and address section it must state the following: WDH - WY Medicaid Provider Enrollment & 122 W. 25th St. 4-West Cheyenne WY 82002, Attn: Sheree Nall***
2. ***The reason for fingerprint must state 42 CFR 455.434***

PLEASE MAKE SURE THE FINGERPRINTS ARE CLEAR AND LEGIBLE OR THEY WILL BE RETURNED.

Failure to comply with this requirement within 30 days of receiving this correspondence shall result in the termination of your provider file.

If you have questions, please feel free to contact me at sheree.nall@wyo.gov or (307-777-8756).

Sincerely,

Sheree Nall

Sheree Nall CPC
Enrollment Program Manager
Division of Healthcare Financing
Office of Medicaid