

**WYOMING EQUALITYCARE CAP LIMIT WAIVER REQUEST FORM**

1. Client Name:

3. Provider Name & Address:

2. Client ID:

4. NPI Number:

5. Which calendar year are you requesting the cap limit waiver for?

6. Instructions: In the space below, please document reason for waiver request (*must be medically necessary*):

7. Physician's Signature (*Must be an original signature, not a stamp*):