

Acknowledgement of Sterilization as a Result of a Hysterectomy

*****REQUIRED: PLEASE PRINT OR TYPE ALL INFORMATION*****

Section I. Patient Information

MEDICAID RECIPIENT'S NAME: _____

RECIPIENT MEDICAID ID #: _____

DATE OF HYSTERECTOMY: _____

Section II. Acknowledgement of receipt of hysterectomy information prior to hysterectomy procedure(s)

I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (sterile). Prior to the hysterectomy, I have been/was informed, both orally and in writing that the hysterectomy would make me permanently incapable of reproducing (sterile). Recipient's Signature:

_____ Date: _____

Section III. Physician's statement

This hysterectomy is not being performed for the sole purpose of rendering the above named recipient permanently incapable of reproducing. Prior to the hysterectomy, the recipient and her representative, if any, were informed both verbally and in writing that the surgical procedure, hysterectomy, would render her permanently incapable of bearing children. I am recommending a hysterectomy for this recipient for the following medical reasons:

Physician's Signature: _____ Date: _____

Section IV. Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure(s)

The patient's acknowledgement was not required because of the following circumstance (check applicable box):

The individual was sterile at the time of the hysterectomy. State the cause of the sterility: _____

The hysterectomy was performed under a life-threatening emergency situation in which I determined prior acknowledgement was not possible. Describe the nature of the emergency:

Physician's Signature: _____ Date: _____

Submit form with claim. Refer to your billing manual for instructions on claim attachments or contact NH Medicaid Provider Relations @ 1-866-291-1674 or nhproviderrelations@conduent.com

State/fiscal agent retention: 3 years minimum (42 CFR 50.208)