UTAH MEDICAID HYSTERECTOMY ACKNOWLEDGMENT FORM

SECTION I: ALWAYS COMPLETE THIS SECTION

Recipient Name_____ Medicaid ID Number_____

Physician Name_____ Date of Hysterectomy_____

Note: **COMPLETE ONLY ONE OF THE REMAINING SECTIONS. COMPLETE ALL BLANKS IN THAT SECTION.**

SECTION A: COMPLETE THIS SECTION FOR A RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

_____
PATIENT'S SIGNATURE DATE

_____
WITNESS' SIGNATURE DATE

_____
PHYSICIAN'S SIGNATURE DATE

_____
INTERPRETER'S SIGNATURE DATE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient, that one of the following conditions applied:
CHECK ONE

□ I informed her that this operation would make her permanently incapable of reproducing. (**This certification is for retroactively eligible recipient only)**

□ She was already sterile. **DESCRIBE THE CAUSE OF STERILITY ON THE LINE BELOW:**

_____

□ She had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy.
DESCRIBE THE EMERGENCY SITUATION BELOW:

_____
_____
_____
_____

_____
PHYSICIAN'S SIGNATURE DATE

SECTION C1: COMPLETE THIS SECTION ONLY FOR A RECIPIENT WHO IS MENTALLY INCOMPETENT

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

_____
PATIENT'S LEGAL REPRESENTATIVE SIGNATURE DATE

_____
WITNESS' SIGNATURE DATE

_____
INTERPRETER'S SIGNATURE DATE

SECTION C2: COMPLETE THIS SECTION ONLY FOR A RECIPEINT WHO IS A MINOR (UNDER AGE 18)

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

_____
PATIENT'S LEGAL REPRESENTATIVE SIGNATURE DATE

_____
WITNESS' SIGNATURE DATE

_____
INTERPRETER'S SIGNATURE DATE

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above recipient was medically necessary due to: **DESCRIBE THE MEDICAL SITUATION BELOW:**

_____
_____
_____

The Hysterectomy was not done for sterilization purposes. To the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent or a minor. Before I performed the hysterectomy on her, I counseled her representative, orally and in writing that, the hysterectomy would render that individual permanently incapable of reproducing; and, the individual's representative has signed a written acknowledgment of receipt of the foregoing information.

_____
PHYSICIAN'S SIGNATURE DATE

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

CLAIMS FOR HYSTERECTOMY SERVICES WILL NOT BE PAID UNTIL THIS FORM IS COMPLETED IN FULL AND RECEIVED BY UTAH MEDICAID. ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE. THIS FORM MAY BE REPRODUCED LOCALLY. PLEASE PROVIDE COPIES FOR PATIENT AND FOR YOUR FILES.

PER TITLE 42 PUBLIC HEALTH CODE OF FEDERAL REGULATIONS (CFR) PART 441, SUBPART F § 441.255 GOVERNS THE HYSTERECTOMIES.

HYSTERECTOMY COVERAGE OVERVIEW

42 CFR 441.255

a. Utah Medicaid does ***not*** cover a hysterectomy if—
- **i.** It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- **ii.** If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

b. Utah Medicaid does cover a hysterectomy if—
- **i.** The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and
- **ii.** The individual or her representative, if any, has signed a written acknowledgment of receipt of that information.
- **iii.** The individual
  - a) was already sterile before the hysterectomy or
  - b) requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible; and
- **iv.** The physician who performs the hysterectomy —
  - a) Certifies in writing that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility; or
  - b) Certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. He/she must also include a description of the nature of the emergency.

SECTION 1 : <u>ALWAYS COMPLETE THIS SECTION</u> (ALL ITEMS IN THIS SECTION MUST BE COMPLETED)

1. Recipient Name: Recipient's Name can be typed or handwritten.
2. Utah Medicaid ID Number. Recipient's Utah Medicaid Number can be typed or handwritten.
3. Physician's Name: Physician's Name can be typed or handwritten.
4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten.

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

1. Witness Signature Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
2. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery. (If the patient cannot sign her name she can make her mark "X" in patient's signature blank if there is a witness. The witness must sign down below his/her name and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting.
3. Physician Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.
4. Interpreter's Signature/Date: If an interpreter was provided, the interpreter must sign his/her name and date simultaneously in his/her own handwriting,

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE

1. Retroactive Eligible Recipient Only: This box is checked only if the Recipient was approved retroactively. The physician who performed the hysterectomy certifies in writing that:
    a. The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing; or
    b. The individual
        i. was already sterile before the hysterectomy; or
        ii. requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible; and
    c. The physician who performs the hysterectomy —
        i. Certifies in writing that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility; or
        ii. Certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. He/she must also include a description of the nature of the emergency.
2. This box is checked if the patient was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.
3. This box is checked if the patient had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.
4. Physician Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

SECTION C1: COMPLETE THIS SECTION FOR MENTALLY INCOMPETENT RECIPIENT

1. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
2. Patient's Legal Representative Signature/Date: Patient representative must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
3. Interpreter's Signature/Date: If an interpreter was provided, the interpreter must sign his/her name and date simultaneously in his/her own handwriting,

SECTION C2: COMPLETE THIS SECTION FOR MINOR (UNDER AGE 18) RECIPIENT

1. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
2. Patient's Legal Representative Signature/Date: Patient representative must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
3. Interpreter's Signature/Date: If an interpreter was provided, the interpreter must sign his/her name and date simultaneously in his/her own handwriting,

PHYSICIAN'S STATEMENT

1. The Physician's Statement portion of this section must be filled out for both mentally incompetent recipient's and minor recipients.
2. Physician Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

Fax or mail the Utah Medicaid Hysterectomy Acknowledgment Form to:

Utah Medicaid Attn: Prior Authorization Unit
P. O. Box 143111
Salt Lake City, Utah 84114-3111
Fax: (801) 536-0162