Nevada Medicaid Hysterectomy Acknowledgement Form

(a) Patient Name_______________________________ **(b) NV Medicaid ID#**_________________________

(c) Diagnosis________________________________ **(d) Date of Hysterectomy**_______________________

(e) Name of Physician________________________________ **(f) NPI #**_____________________________

(g) Physician's Street Address_______________________________ **(h) City, State, Zip**________________

I. If the patient signs the hysterectomy acknowledgement statement PRIOR TO surgery, the following section must be completed by the patient or her representative and physician.

I HAVE BEEN INFORMED ORALLY AND IN WRITING ON **(i)**_____/_____/_____ BY **(j)**________________________________THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

(k) Date Signed_____/_____/_____ **(l) Patient/Representative** Signature__________________

(m) Physician Signature_________________________________

II. If the patient signs the hysterectomy acknowledgement statement AFTER surgery, the following section must be completed by the patient or her representative and physician.

PRIOR TO MY SURGERY ON **(n)** ____/_____/_____, I WAS INFORMED ORALLY AND IN WRITING BY **(o)** ____THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

(p) Date Signed _____/_____/____**(q) Patient/Representative** Signature_________________

(r) Physician Signature_________________________________

III. If the patient was sterile prior to surgery OR if the hysterectomy was performed on an emergency basis, the physician must certify such by completing ONE of the following statements.

(MEDICAL RECORDS MUST BE ATTACHED TO DOCUMENT ITEMS C OR D)

A. Patient is sterile because she is post menopausal at age of **(s)**_________. Her date of birth is **(t)** ____/_____/_____.
B. Patient is sterile because she has a history of previously having the sterilization procedure, **(u)**____ on **(v)**_____/_____/_____.
C. Patient is sterile due to **(w)**____.
D. Patient required the hysterectomy and prior acknowledgement was not possible due to the life-threatening situation of **(x)**____.

(y) Date Signed_____/_____/_____**(z) Physician** Signature___________________________

Nevada Medicaid Hysterectomy Acknowledgement Form

INSTRUCTIONS FOR COMPLETION
OF NEVADA MEDICAID
HYSTERECTOMY ACKNOWLEDGMENT FORM

Federal Medicaid regulations require that a hysterectomy acknowledgment statement be completed before payment can be made for hysterectomy claims. The exceptions are (1) the patient was sterile prior to the procedure or (2) the patient required the hysterectomy on an emergency basis because of life-threatening circumstances. The physician (surgeon) is responsible for submitting the completed form to the Fiscal Agent either **prior to or with** the claim(s) for the hysterectomy.

The following instructions correspond with the appropriate blanks on the form. After completing the identification lines, select and complete Section I, II, **OR** III. **Except for the signature spaces,** it is acceptable for a designated person other than the patient or physician to type or print the appropriate information in the blanks. **Remember that only ONE section in addition to the identification section is to be completed.**

IDENTIFICATION: Complete for proper identification of the patient.

a. Type or print the patient's full name as shown on the Medicaid ID card.
b. Type or print the patient's Medicaid ID# as shown on the Medicaid ID card.
c. Type or print the patient's diagnosis which is relevant to the hysterectomy.
d. Type or print the date of the hysterectomy.
e. Type or print the full name of the physician (surgeon).
f. Type or print the physician's (surgeon) NPI #.
g. Type or print the physician's (surgeon) street address.
h. Type or print the city, state, and zip code for the physician's (surgeon) address.

SECTION I: Complete if patient is signing form PRIOR TO hysterectomy.

i. Type or print the date that the patient received the oral and written information.
j. Type or print the name/title of the physician (surgeon) or other person providing the information.
k. Type or print the date of the patient or representative's signature.
l. The patient or her representative must sign in this space.
m. The physician (surgeon) must sign in this space.

Section II: Complete if patient is signing form AFTER hysterectomy.

n. Type or print the date of the hysterectomy.
o. Type or print the name/title of the physician (surgeon) or other person providing the information.
p. Type or print the date of the patient or representative's signature.
q. The patient or her representative must sign in this space.
r. The physician (surgeon) must sign in this space.

Section III: Choose A, B, C, or D if patient is already sterile or if life threatening emergency case.

s. Type or print the patient's age. **THE PATIENT MUST BE POST MENOPAUSAL.**
t. Type or print the patient's date of birth (Month, Day, Year). An example is 10 05 35.
u. Type or print the name of the previous sterilization procedure **(DO NOT ABBREVIATE).**
v. Type or print the year of the previous sterilization procedure.
w. Type or print the condition(s) other than age or previous sterilization procedure that caused the patient to be sterile. **REMEMBER TO ATTACH MEDICAL RECORDS THAT DOCUMENT THE CONDITIONS THAT CAUSED THE PATIENT TO BE STERILE.**
x. Type or print the emergency surgery condition/procedure. **REMEMBER TO ATTACH COMPLETE MEDICAL RECORDS THAT DOCUMENT THE LIFE THREATENING EMERGENCY CASE.**
y. Type or print the date of the physician's (surgeon) signature.
z. The physician (surgeon) must sign in this space.