A properly completed Hysterectomy Acknowledgment Form **MUST** accompany claims submitted for this service. This form may be obtained from the fiscal agent. The person who secures this authorization **MUST** inform the individual and her representative, if any, orally and in writing that the hysterectomy will make her permanently incapable of reproducing. The individual and her representative, if any, **MUST** sign a written acknowledgment of receipt of the information.

The acknowledgment form is not required when the following circumstances exist:

- The individual is already sterile at the time of the hysterectomy; or
- The individual requires a hysterectomy because of a life-threatening emergency where the physician determines that prior acknowledgment is not possible.

If one or both of these circumstances exist, documentation must appear on the face of the claim to certify that:

- The woman was already sterile, stating the cause of that sterility; or
- The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. He/She must include a description of the nature of the emergency.

The Hysterectomy Acknowledgment Form is a pale yellow form. Although a provider may photocopy and use the form that follows, it is recommended that you obtain a supply of original forms from the fiscal agent.

Please note: Form MA-1002 has two (2) sides -- the actual form on the front side and instructions for completion on the reverse side.

MISSISSIPPI MEDICAID HYSTERECTOMY ACKNOWLEDGMENT FORM

Patient Name(1)_____ **MS Medicaid ID#(2)**_____

Street Address(3)_____ **City, State, Zip(4)**_____

Diagnosis(5)_____ **Date Of Hysterectomy(6)**_____

Name Of Physician(7)_____ **MS Medicaid Provider #(8)**_____

Street Address(9)_____ **City, State, Zip(10)**_____

I. <u>If the patient signs the hysterectomy acknowledgment statement PRIOR TO surgery, the following section must be completed by the patient or her representative and physician.</u>

I HAVE BEEN INFORMED ORALLY AND IN WRITING ON (11)_____ BY (12)_____ THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

Date Signed(13)_____ **Patient/Representative** Signature(14)_____

Physician Signature(15)_____

II. <u>If the patient signs the hysterectomy acknowledgment statement AFTER surgery, the following section must be completed by the patient or her representative and physician.</u>

PRIOR TO MY SURGERY ON(16)_____, I WAS INFORMED ORALLY AND IN WRITING BY (17)_____ THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

Date Signed(18)_____ **Patient/Representative** Signature(19)_____

Physician Signature(20)_____

III. <u>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.</u>

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

A. Patient is sterile because she is post menopausal at age of (21) _____. Her date of birth is (22)_____ _____ _____.
B. Patient is sterile because she has a history of previously having the sterilization procedure, (23)_____, in (24)_____.
C. Patient is sterile due to (25)_____.
D. Patient required the hysterectomy and prior acknowledgment was not possible due to the life-threatening situation of (26)_____.

Date Signed(27)_____ **Physician** Signature(28)_____

MA-1002

INSTRUCTIONS FOR COMPLETION
OF MISSISSIPPI 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.

1. Type or print the patient's full name as shown on the Medicaid ID card.
2. Type or print the patient's Medicaid ID# as shown on the Medicaid ID card.
3. Type or print the patient's street address.
4. Type or print the city, state, and zip code for the patient's address.
5. Type or print the patient's diagnosis which is relevant to the hysterectomy.
6. Type or print the date of the hysterectomy.
7. Type or print the full name of the physician (surgeon) .
8. Type or print the physician's (surgeon) MS Medicaid Provider Number.
9. Type or print the physician's (surgeon) street address.
10. 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.

11. Type or print the date that the patient received the oral and written information.
12. Type or print the name/title of the physician (surgeon) or other person providing the information.
13. Type or print the date of the patient or representative's signature.
14. The patient or her representative must sign in this space.
15. The physician (surgeon) must sign in this space.

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

16. Type or print the date of the hysterectomy.
17. Type or print the name/title of the physician (surgeon) or other person providing the information.
18. Type or print the date of the patient or representative's signature.
19. The patient or her representative must sign in this space.
20. 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.

21. Type or print the patient's age. **THE PATIENT MUST BE POST MENOPAUSAL.**
22. Type or print the patient's date of birth (Month, Day, Year). An example is 10 05 35.
23. Type or print the name of the previous sterilization procedure **(DO NOT ABBREVIATE).**
24. Type or print the year of the previous sterilization procedure.
25. 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.**
26. Type or print the emergency surgery condition/procedure. **REMEMBER TO ATTACH COMPLETE MEDICAL RECORDS THAT DOCUMENT THE LIFE THREATENING EMERGENCY CASE.**
27. Type or print the date of the physician's (surgeon) signature.
28. The physician (surgeon) must sign in this space.