The Medicaid Program reimburses claims for sterilizations, hysterectomies and abortions in compliance with all federal and state regulations. In order to meet all guidelines, claims for these services must be filed as explained below. Any claim paid and subsequently found to be out of compliance with federal and/or state guidelines will be recouped.

Medicaid will cover sterilization procedures if they meet the Medicaid criteria listed below for a covered sterilization. **There are no exceptions for each criterion.**

The following criteria apply to all types of sterilization procedures, both male and female:

1. The beneficiary must be **mentally competent.** Medicaid benefits are not available for sterilization of a mentally incompetent or institutionalized individual.

2. The beneficiary must be **21 years old when the consent form is signed.**

3. The beneficiary and **only** the beneficiary must sign the consent form **voluntarily**.

4. The consent form is **valid for 180 days** from the date it is signed by the patient.

5. The consent form must be **fully** and **accurately** completed.

6. There must be **at least a 30-day waiting period** between the date that the beneficiary signs the form and the date of the surgery.

An individual may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. **In the case of premature delivery, the informed consent must have been given at least thirty (30) days before the expected date of delivery**.

Caesarean deliveries are not routinely considered as emergency abdominal surgery.

The Division of Medicaid will require the appropriate medical documentation to justify any emergency abdominal procedures or premature deliveries. For premature deliveries, the physician must document the expected date of delivery.

When submitting the claim for sterilization services, the provider MUST attach a copy of the Sterilization Consent Form if one is not already on file with the fiscal agent. The form may be obtained from the fiscal agent. This form is required of all providers (i.e., primary and assistant surgeon, anesthesiologist, and hospital) involved in the sterilization procedure. The Sterilization Consent Form has four (4) parts and should be completed fully and accurately.

The Sterilization Consent Form should be completed as follows:

1. Consent to Sterilization

- Name of doctor or clinic MUST be entered
- Name of operation MUST be entered.

- Patient's date of birth MUST be entered.
- Patient's name MUST be entered.
- Name of doctor MUST be entered.
- Name of operation MUST be entered.
- Form MUST be signed and dated by the beneficiary.

2. Interpreter's Statement

- If an interpreter is necessary, that individual MUST complete this section, sign, and date the form on the same date as the beneficiary.

3. Statement of Person Obtaining Consent

- Patient's name MUST be entered.
- Name of operation MUST be entered.
- Person obtaining the consent MUST sign and date the form on the same day it was signed and dated by the beneficiary.
- Name and address of the facility where the consent is obtained MUST be entered.

4. Physician's Statement

- Name of individual MUST be entered.
- Date of sterilization MUST be entered.
- Type of operation MUST be entered.
- If paragraph (2) is true, the appropriate "block" MUST be checked.
- The physician performing the surgery MUST sign and date the form AFTER completing the operation.

Some general guidelines for filing sterilization claims:

1. The beneficiary must be 21 years old when the consent form is signed;
2. The consent form is valid for 180 days from the date it was signed by the patient; and
3. There must be at least a 30-day waiting period between the date the beneficiary signs the form and the date of the surgery. If emergency abdominal surgery is performed, the sterilization may be performed if 72 hours have elapsed from the time the beneficiary signed the form. **STERILIZATIONS PERFORMED BEFORE THE 30-DAY WAITING PERIOD OR THE 72-HOUR LIMIT WILL NOT BE REIMBURSED.**

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health, Education, and Welfare or
Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.
I have received a copy of this form.

_____ Date: _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity destination (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent.
I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization), I explained to him/her the nature of the _____ (operation) sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician Date

PATIENT NAME _____ **MEDICAID I.D. #** _____

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White: PATIENT **Yellow:** PHYSICIAN **Pink:** STATE AGENCY

Failed Sterilization Procedures

The Division of Medicaid (DOM) provides coverage for covered sterilization procedures for males or females as "once-per-lifetime". In the event a second sterilization procedure is required due to failure of the first procedure, coverage will be provided for a second covered procedure. Documentation must be maintained in the beneficiary's medical record for the reason for the procedure failure and the date of the first sterilization.