

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

Always Complete Items 1 – 4.

1. Individual's Name: Individual's name can be typed or handwritten. Must be completed.
2. Individual's Date of Birth: Individual's date of birth can be typed or handwritten. Must be completed.
3. Physician's Name: Physician's name can be typed or handwritten. Must be completed.
4. Date of Hysterectomy: Date hysterectomy was performed can be typed or handwritten. Must be completed.

*******AT MINIMUM ONE OF THE BELOW SECTIONS (A-C) SHOULD BE COMPLETED*******

SECTION A: Complete This Section Only For Individuals With Current TennCare Eligibility Who Acknowledges Receipt Prior To Hysterectomy. If Section B or Section C is applicable, completion of Section A is not necessary.

5. Witness Signature/Date: Witness must sign his/her name and date in his/her own handwriting prior to surgery.
6. Individual's Signature/Date: Individual must sign her name and date in her own handwriting prior to surgery. A signature is a sign or mark by the recipient on a document signifying knowledge, approval, acceptance and informed consent.

If Section A is completed, STOP HERE.

SECTION B: Complete This Section Only When One Of The Following Three Exceptions (1-3) Listed Below Is Applicable For The Individual, If Section A or Section C is applicable, completion of Section B is not necessary.

7. Retroactive Eligible Individual Only: This box is checked only if the individual was approved retroactively. A copy of the MCO ID Card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.
8. Individual Already Sterile: This box is checked if the individual was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.
9. Life-threatening Situation: This box is checked if the individual 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.
10. Physician's Signature/Date: The physician must sign his/her name and date in his/her own handwriting.

If Section B is completed, STOP HERE.

SECTION C: Complete This Section Only For Mentally – Incompetent Individuals. If Section A or Section B is applicable, completion of Section C is not necessary.

11. Witness Signature/Date: Witness must sign his/her name and date in his/her own handwriting prior to surgery.
12. Individual Representative Signature/Date: Individual's representative must sign his/her name and date in his/her own handwriting prior to surgery.
13. Physician's Statement: Describe the reason for the hysterectomy. This may be typed or handwritten.
14. Physician's Signature/Date: The physician must sign his/her name and date in his/her own handwriting after surgery.

MEDICAID - TITLE XIX ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

→ Step 1.) ALWAYS COMPLETE THIS SECTION

Individual's Name _____ **1** Individual's Date of Birth _____ **2**
 Physician's Name _____ **3** Date of Hysterectomy _____ **4**

→ Step 2.) COMPLETE AT MINIMUM ONE OF THE REMAINING SECTIONS BELOW (Section A, B or C). COMPLETE ALL INDICATED BLANKS IN THAT SECTION.

SECTION A: COMPLETE THIS SECTION WHEN THE INDIVIDUAL WITH CURRENT TENNCARE ELIGIBILITY ACKNOWLEDGES RECEIPT OF HYSTERECTOMY INFORMATION PRIOR TO THE HYSTERECTOMY BEING PERFORMED.

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.

_____ **5** _____ **5** _____ **6** _____ **6**
 WITNESS' SIGNATURE DATE INDIVIDUAL'S SIGNATURE DATE

OR

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

I certify that before I performed the hysterectomy procedure on the Individual indicated:

CHECK ALL THAT APPLY

1 I informed her that this operation would make her permanently incapable of reproducing. (**THIS CERTIFICATION IS FOR RETROACTIVELY ELIGIBLE INDIVIDUALS ONLY** - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made)

2 She was already sterile due to:
8 _____
 CAUSE OF STERILITY

3 She had a hysterectomy performed because of a life-threatening situation due to:
9 _____
 DESCRIBE EMERGENCY SITUATION

and the information concerning sterility could not be given prior to the hysterectomy.

_____ **10** _____ **10**
 PHYSICIAN'S SIGNATURE DATE

OR

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT INDIVIDUALS ONLY

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 Individual, it will render her permanently incapable of reproducing.

_____ **11** _____ **11** _____ **12** _____ **12**
 WITNESS' SIGNATURE DATE INDIVIDUAL'S REPRESENTATIVE SIGNATURE DATE

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above Individual was medically necessary due to:

_____ **13**
 REASON FOR HYSTERECTOMY

and was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. 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.

_____ **14** _____ **14**
 PHYSICIAN'S SIGNATURE DATE

MEDICAID - TITLE XIX ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

→ Step 1.) ALWAYS COMPLETE THIS SECTION

Individual's Name _____ Individual's Date of Birth _____
 Physician's Name _____ Date of Hysterectomy _____

→ Step 2.) COMPLETE AT MINIMUM ONE OF THE REMAINING SECTIONS BELOW (Section A, B or C). COMPLETE ALL INDICATED BLANKS IN THAT SECTION.

SECTION A: COMPLETE THIS SECTION WHEN THE INDIVIDUAL WITH CURRENT TENNCARE ELIGIBILITY ACKNOWLEDGES RECEIPT OF HYSTERECTOMY INFORMATION PRIOR TO THE HYSTERECTOMY BEING PERFORMED.

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.

 WITNESS' SIGNATURE DATE INDIVIDUAL'S SIGNATURE DATE

OR

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

I certify that before I performed the hysterectomy procedure on the Individual indicated:

**CHECK ALL
THAT APPLY**

1 I informed her that this operation would make her permanently incapable of reproducing. (**THIS CERTIFICATION IS FOR RETROACTIVELY ELIGIBLE INDIVIDUALS ONLY** - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made)

2 She was already sterile due to:

CAUSE OF STERILITY

3 She had a hysterectomy performed because of a life-threatening situation due to:

DESCRIBE EMERGENCY SITUATION

and the information concerning sterility could not be given prior to the hysterectomy.

 PHYSICIAN'S SIGNATURE DATE

OR

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT INDIVIDUALS ONLY

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 Individual, it will render her permanently incapable of reproducing.

 WITNESS' SIGNATURE DATE INDIVIDUAL'S REPRESENTATIVE SIGNATURE DATE

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above Individual was medically necessary due to:

REASON FOR HYSTERECTOMY

and was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. 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