# 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.

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

**SECTION A:** Complete This Section Only For Individual With Current TennCare Eligibility Who Acknowledges Receipt Prior To Hysterectomy. **If Section B or Section C is applicable, do not complete this section.**

5. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.

6. Individual's Signature/Date: Individual must sign her name and date in her own handwriting simultaneously prior to surgery. (If the individual cannot sign her name, she can make her mark "X" in Individual's Signature blank if there is a witness. The witness must sign down below Individual's Signature blank and simultaneously date the day they witnessed the Individual make her mark. This must be in the witness' own handwriting. The witness should write witness beside their name.)

**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, do not complete this section**.

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 simultaneously 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, do not completed this section.**

11. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.

12. Individual Representative Signature/Date: Individual's representative must sign his/her name and date simultaneously 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 simultaneously in his/her own handwriting after surgery.

****ONLY ONE OF THE ABOVE SECTIONS (A-C) SHOULD BE COMPLETED****

TennCare, a Division of Health Care Finance and Administration Rev. April 22, 2015

# 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 **ONLY ONE** OF REMAINING SECTIONS BELOW (Section A, B or C) AND BE SURE TO COMPLETE ALL INDICATED BLANKS IN THAT SECTION).
**DO NOT COMPLETE MORE THAN ONE 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 **WITNESS' SIGNATURE** 5 **DATE** 6 **INDIVIDUAL'S SIGNATURE** 6 **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 ONE**

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)
7

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 **PHYSICIAN'S SIGNATURE** 10 **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 **WITNESS' SIGNATURE** 11 **DATE** 12 **INDIVIDUAL'S REPRESENTATIVE SIGNATURE** 12 **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 **PHYSICIAN'S SIGNATURE** 14 **DATE**

Attach a copy to claim form when submitting for payment. Provide copies for individual and for your files.
ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.

TennCare, a Division of Health Care Finance and Administration Rev. April 22, 2015

# 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 **ONLY ONE** OF REMAINING SECTIONS BELOW (Section A, B or C) AND BE SURE TO COMPLETE ALL INDICATED BLANKS IN THAT SECTION).
**DO NOT COMPLETE MORE THAN ONE 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 ONE**

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**

Attach a copy to claim form when submitting for payment. Provide copies for individual and for your files.
ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.