TENNCARE INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

ASH Forms FAQ

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.

Revised May 26, 2022

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 **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 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) 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.

Revised May 26, 2022

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**

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.