Texas Medicaid - Title XIX
Acknowledgment of Hysterectomy Information

Attach a copy to claim form when submitting for payment. Provide copies for patient and your files.

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

Always Complete This Section

1. Client Name: Client's name can be typed or handwritten. Must be completed.
2. Client Medicaid ID No.: Client's Medicaid number 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 Surgery: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete This Section for Clients Who Acknowledge Receipt Prior to Hysterectomy

5. Client Signature / Date: Client must sign her name and date simultaneously in her own handwriting prior to surgery. (If the client cannot sign her name she can make her mark "X" in the client's signature blank if there is a witness. The witness must sign and simultaneously date the day they witnessed the client make their mark. This must be in the witness's own handwriting.)

If Section A is completed, STOP HERE.

Section B: Complete This Section When Any Of The Exceptions Listed Below Is Applicable

6. Sterility: This box is checked if the client was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.
7. Emergency Situation: This box is checked if the client 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.
8. Retroactively Eligible Clients Only: This box is checked only if the client was approved retroactively. 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 reimbursement can be made.
9. Physician's Signature/Date: The physician must sign his or her name and date simultaneously in his or her own handwriting.

Section C: Complete This Section For Mentally-Incompetent Client Only

10. Client Representative Signature/Date: Client representative must sign his or her name and date simultaneously in his or her own handwriting prior to surgery.
11. Witness Signature/Date: Witness must sign his or her name and date simultaneously in his or her own handwriting prior to surgery.
12. Reason For Hysterectomy: Describe the reason for the hysterectomy. This may be typed or handwritten.
13. Physician Signature/Date: The physician must sign his or her name and date simultaneously in his or her own handwriting after surgery.

SECTION D: Interpreter's Statement (If applicable)

14. Name of Language Used by Interpreter.
15. Interpreter's Signature.
16. Date of Interpreter's Signature (month, day, year).

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ALWAYS COMPLETE THIS SECTION

Client Name	Client Medicaid ID No.
Physician's Name	**Date of Surgery**

COMPLETE ONLY ONE OF REMAINING SECTIONS. COMPLETE ALL BLANKS IN THAT SECTION

Section A: Complete this section for client who acknowledges receipt prior to hysterectomy

By signing this form, I am confirming that: I have been told by my doctor before surgery (a hysterectomy) that, if I get this surgery, I will not be able to get pregnant after this surgery (a hysterectomy).

Client Signature	Date	Witness Signature	Date

Sección A: Complete esta sección para el cliente que reconoce recibo antes de una histerectomía

Al firmar este formulario confirmo que: Antes de la cirugía (una histerectomía), el doctor me dijo que al hacerme esta cirugía, no podré quedar embarazada después de la cirugía (una histerectomía).

Firma del cliente	Fecha	Firma de un testigo	Fecha

Section B: Complete this section when any of the exceptions listed below is applicable

I certify that before I performed the hysterectomy procedure on the client listed above:

CHECK ONE

☐ She was already sterile due to (DESCRIBE CAUSE OF STERILITY)

_____

☐ 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.

This certification for retroactively eligible recipient only –

☐ I informed her that this operation would make her permanently incapable of reproducing. Note: 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.

Physician's Signature	Date

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Section C: Complete this section for mentally-incompetent client only

By signing this form, I am confirming that: I have been told by the doctor before surgery (a hysterectomy) that, if the above client gets this surgery, she will not be able to get pregnant after this surgery (a hysterectomy).

Client Representative Signature	Date	Witness Signature	Date

Physician's Statement

I affirm that the hysterectomy I performed on the above client was medically necessary due to:
(DESCRIBE REASON FOR THE 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

Section D: Complete this section if an interpreter is provided to assist the individual to be sterilized

I provided translation services for the doctor who will perform the hysterectomy on the client. I have translated all of the doctor's information and advice for the client.

I have also read the consent form to the client in the _____ language and explained its contents to her. To the best of my knowledge and belief, she has understood this explanation.

Interpreter's Signature	Date

ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE
THIS FORM MAY BE REPRODUCED LOCALLY