VIRGINIA MEDICAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PATIENT ACKNOWLEDGMENT

Recipient Eligibility Number: _____

It has been explained to _____ of
(Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

_____ _____
(Recipient's or Representative's Signature) (Date)

If Required: _____ _____
(Interpreter's Signature) (Date)

PHYSICIAN STATEMENT

I, Doctor _____, certify that the hysterectomy

performed _____ on _____ of
(Date of Operation) (Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

(X) MARK THE APPROPRIATE BLOCK

A ☐ was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.

B ☐ was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Acknowledgment of Receipt of Hysterectomy Information. The life-threatening emergency situation was

_____

_____
(A Description of the Nature of the Emergency)

C ☐ was performed subsequent to the patient being sterile. This judgment is based on the following condition(s): _____

_____

_____ _____
(Physician's Signature) (Date)

(A COPY OF THE COMPLETED CERTIFICATION MUST BE ATTACHED TO EACH INVOICE FOR A HYSTERECTOMY PROCEDURE. THE SURGEON MUST PROVIDE COPIES TO OTHER PROVIDERS FOR THEIR USE WHEN BILLING MEDICAID.)

MAP-3005 R 8/84

PHYSICIAN COPY

INSTRUCTIONS FOR COMPLETING HYSTERECTOMY CERTIFICATION

This form must be completed and a copy attached to each invoice submitted by a physician, hospital, and other providers of care when a hysterectomy is performed where Medicaid reimbursement is expected. A copy must be maintained in the provider's patient file.

PATIENT ACKNOWLEDGMENT

The patient must be informed prior to surgery, unless life-threatening conditions exist, that the hysterectomy will render her permanently incapable of reproducing. The Acknowledgment of Receipt of Hysterectomy Information (MAP-3006) may be signed before or after the surgery is performed.

Recipient Eligibility Number:
Enter the twelve- (12-) digit Medicaid eligibility number from the recipient's eligibility card.

Recipient's Name:
Enter the name of the patient.

Address:
Enter the patient's address.

Recipient's or Representative's Signature:
The signature of the patient or her representative, if patient is unable to sign.

(The patient or her representative may sign before or after the surgery is performed as long as the individual was informed prior to surgery.)

Date:
Enter the date signed.

PHYSICIAN'S STATEMENT

I, Dr. _____ ...

Enter the name of the physician who performed the hysterectomy.

Date of Operation:
Enter the date of the operation.

Recipient's Name:
Enter the name of the recipient/patient.

Address:
Enter the recipient/patient's complete address.

A ___ Enter "X" if statement is appropriate.

B ___ Enter "X" if life-threatening emergency situation; also enter a description of the nature of the emergency.

C ___ Enter an "X" if patient was sterile prior to performing surgery. Also enter the condition(s) which existed prior to the hysterectomy which rendered the person incapable of reproducing.

Physician's Signature and Date:
The physician performing the hysterectomy is required to place an "X" in block A, B, or C as appropriate, fill in the necessary explanations, and sign and date the Physician's Statement.

IMPORTANT:

The patient or her representative must sign the Patient Acknowledgment section before the hysterectomy is performed if other than life-threatening condition.

The physician must sign the Physician's Statement after the hysterectomy is performed.