ATTACHMENT I

ALABAMA MEDICAID AGENCY HYSTERECTOMY CONSENT FORM

See the back of this form for instructions on completing and submitting the form

PART I. PHYSICIAN

Certification by Physician Regarding Hysterectomy

I hereby certify that I have advised ______________________ Medicaid Number ______________________ to
Name of Patient

undergo a hysterectomy because of the diagnosis of ______________________, ______________.
diagnosis code

Further, I have explained orally and in writing to this patient and/or her representative (______________________) that she will be
Name of Representative, if any

permanently incapable of reproducing as a result of this operation which is medically necessary. This explanation was given before the operation was performed.

______________________ *Name of Physician*

______________________ NPI #

______________________ *Signature of Physician*

______________________ *Date of Signature*

PART II. PATIENT

Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information

I, ______________________ and/or ______________________ hereby acknowledge that
Name of Patient *Date of Birth* *Name of Representative, if any*

I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation. This oral and written explanation that the hysterectomy would make me sterile was given to me before the operation.

______________________ *Signature of Patient*

______________________ *Date*

______________________ *Signature of Representative, if any*

______________________ *Date*

PART III. PHYSICIAN

Date of Surgery ______________________

PART IV. UNUSUAL CIRCUMSTANCES

Recipient Name: ______________________ Recipient ID: ______________________

I ______________________ certify
Printed name of physician

- ☐ patient was already sterile when the hysterectomy was performed. Cause of sterility ______________________. Medical records are attached.
- ☐ hysterectomy was performed under a life threatening situation. Medical records are attached.
- ☐ hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.

Before the operation was performed, I informed the recipient that she would be permanently incapable of reproducing as a result of this operation. ☐ Yes ☐ No

Signature: ___ ______________________ Date: ____ ______________

PART V. STATE REVIEW DECISION

Signature of Reviewer: ______________________ Date of Review: ____________ ☐ Pay ☐ Deny

Reason for denial: ______________________

Hysterectomy Form Instructions

Part I.

This section is required for all routine hysterectomies. See Part III and IV for a patient who is already sterile, a hysterectomy performed under life-threatening emergency or during a period of retroactive Medicaid eligilbity.

- Enter the name of the patient.
- Enter the recipient's 13 digit Medicaid Number.
- Enter the diagnosis description requiring hysterectomy.
- Enter the diagnosis code.
- Enter the name of the representative if the recipient is unable to sign the consent form. If a representative is not used enter N/A in the field.
- Enter name of the physician who will perform the hysterectomy.
- Enter the NPI Number of the physician who will perform the hysterectomy.
- Physician must sign their name and enter the date of signature. Date must be the date of the surgery or a prior date. **If any date after surgery is recorded, the form will be denied.**

Part II.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Enter the name of the patient and the patient's date of birth including the day/month/year.
- Enter the name of representative if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field.
- Patient must sign and enter the date of signature unless a representative is being used to complete the form. Date must be the date of surgery or a prior date. **If any date after surgery is recorded, the form will be denied.**
- Representative must sign and enter the date of signature if the recipient is unable to sign the consent form. Date must be the date of the surgery or a prior date. **If any date after surgery is recorded, the form will be denied.**

PART III.

This section is required for all hysterectomies.

- Enter the date of surgery once the surgery has been performed.

PART IV.

This section is for use when a hysterectomy was performed on a patient who was already sterile, under a life-threatening emergency in which prior acknowledgement was not possible or during a period of retroactive Medicaid eligibility. Medical records must be submitted for any hysterectomy recorded under this section. In lieu of this form, a properly executed informed consent and medical records may be submitted for these three circumstances.

- Enter name of the patient.
- Enter the recipient's 13 digit Medicaid Number.
- Enter the name of the physician who performed the surgery.
- Check the appropriate box to indicate the specific unusual circumstance.
- Check the appropriate box regarding whether or not the patient was informed she would be permanently incapable of reproducing as a result of the operation.
- Physician must sign their name and enter the date of signature.

PART V.

The reviewer at the State completes this section whenever unusual circumstances are identified. Gainwell will send a copy of the consent form containing the State payment decision to the surgeon following State review.

SUBMISSION INSTRUCTIONS:

Effective October 26, 2016, the physician **must** submit this form via Provider Web Portal upload or fax with supporting medical records (Medical History, Operative Records, Discharge Summary and a Hospital Consent Form for Hysterectomy) and claim to Gainwell.

Refer to Chapter 5 (Filing Claims) for instructions on the digital submission of the Hysterectomy Consent Form and supporting documentation.

NOTE: If submitting this form via fax, a barcode fax coversheet is required with each submission and should be included as page one of the fax transmission for the corresponding Record ID.

Fax form to Gainwell at: (334) 215-7416.