



Awareness Form

Appendix G – Awareness Form

441.255 Sterilization by hysterectomy

(a) FFP is not available in expenditures for a hysterectomy if --

(1) It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or

(2) If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing

(b) FFP is available in expenditure for a hysterectomy not covered by paragraph (a) of this section if --

(1) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing; and

(2) The individual or her representative, if any, has signed with a written acknowledgement of receipt of that information.
441.256

Patient's Name: _____

Medicaid No. _____ Date of Surgery _____

Physician's Name: _____

Surgical Procedure: _____

Section A: Complete this section for patient's apparently presently capable of reproducing:

1. Patient acknowledgement:

It has been explained to me that the surgical procedure to be performed is medically necessary and as a result will render me permanently incapable of reproducing.

Date: _____
Patient's Signature (or Patient's Representative)

Date: _____
Interpreter's Signature

2. Physician Certification:

The surgical procedure to be performed on _____ is medically indicated and is not solely for the purpose of rendering her permanently incapable of reproducing.
Patient's Name

Date: _____ Physician's Signature: _____

Section B: Complete this section for other patients:

The surgical procedure to be performed on this patient is medically necessary and is unrelated to her ability to reproduce for the following reasons:

_____ This patient was surgically sterilized on _____ approximate date

_____ This patient is post menopausal.

_____ This patient's reproductive capability will be maintained.

_____ Other as specified: _____

Date: _____ Physician's Signature: _____