ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

This form must be completed when a hysterectomy is to be performed which is not precluded from Medicaid reimbursement under Federal regulatory provisions at 42 CFR 441.255(a) and which is not exempted from the requirement for this documentation under provisions at 42 CFR 441.255(d) or (e).

The requirement for Acknowledgment of Receipt of Hysterectomy information applies to an individual of any age. The form must be signed by the participant or their representative, if any, prior to surgery. Hysterectomies for family planning purposes are not payable through Medicaid or any other federally funded program, nor from the general relief or blind pension programs.

This completed form must be attached to the MO HealthNet paper claim or submitted online through eMOMED.

Participant Information

Participant Name	MO HealthNet ID Number	Name of Representative (if applicable)

Source of Hysterectomy Information (Name of physician, nurse, family planning counselor who secured authorization)

To Be Completed By The Person Who Secures the Authorization to Perform the Hysterectomy

I certify that I have informed the above named participant and her representative, if any, orally and in writing, that the hysterectomy render her permanently incapable of reproducing. I further certify that the purpose (medical reason) of performing the hysterectomy is:

Title of Person Securing Authorization		Date Authorization Secured
Signature of Person Securing Authorization		**Date**
Physician/Clinic Name	**NPI**	**Provider Taxonomy Code**

To Be Completed By the Participant Receiving the Hysterectomy Prior To the Operation

I have received, orally and in writing, information from the above named source, stating that the hysterectomy will render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

Signature of Participant	Date

To Be Completed by a Representative of the Participant Receiving the Hysterectomy (if applicable)

If this section is completed, the reason the participant is incapable of signing must be stated on the line provided. If the participant is capable of signing above, this section should not be completed.

I, the representative named above, certify that the designated participant accepts and understands that I am her representative and that she has received, orally and in writing, information from the above named source, stating that the hysterectomy will render her permanently incapable of reproducing. She understands that she will not be able to become pregnant or bear children.

Reason Participant is Incapable of Signing

Name of Representative	Relationship to Participant

Signature of Representative	Date