MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

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 Acknowledgement of Receipt of Hysterectomy Information applies to an individual of any age. The form must be signed by the recipient or her 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.

1. NAME OF PARTICIPANT	2. MO HEALTHNET ID NUMBER	3. NAME OF REPRESENTATIVE

4. SOURCE OF HYSTERECTOMY INFORMATION

PART I

TO BE COMPLETED BY THE PERSON WHO SECURES THE AUTHORIZATION TO PERFORM THE HYSTERECTOMY.

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

6. SIGNATURE AND TITLE OF PERSON SECURING AUTHORIZATION	7. DATE (MONTH/DAY/YEAR)

8. PHYSICIAN/CLINIC NAME

9A. MO HEALTHNET PROVIDER IDENTIFIER	9B. PROVIDER TAXONOMY CODE

PART II (COMPLETE A OR B)

If B is completed, the reason the participant is incapable of signing must be stated on the line provided in Item B. (B is not to be completed if the participant is capable of signing in item A.)

A. 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.

10. SIGNATURE OF PARTICIPANT	11. DATE (MONTH/DAY/YEAR)

B. TO BE COMPLETED BY A REPRESENTATIVE OF THE PARTICIPANT RECEIVING THE HYSTERECTOMY.

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.

12. REASON PARTICIPANT INCAPABLE OF SIGNING

13. SIGNATURE OF REPRESENTATIVE	14. RELATIONSHIP TO PARTICIPANT	15. DATE (MONTH/DAY/YEAR)

FIELD NUMBER	INSTRUCTIONS FOR COMPLETION
(1)	Name of MO HealthNet participant.
(2)	Participant MO HealthNet ID Number
(3)	Name of participant's representative, if any. (Legal guardian, husband, etc.)
(4)	Name of physician, nurse, family planning counselor who secured authorization.
(5)	The medical reason for hysterectomy.
(6)	Signature and title of person informing patient that the hysterectomy will render her permanently incapable of reproducing. (Physician, nurse, family planning counselor, etc.)
(7)	Date authorization secured.
(8)	Performing physician or name of clinic securing authorization.
(9A)	MO HealthNet identifier of provider securing authorization.
(9B)	Provider Taxonomy code of MO HealthNet provider
(10)	Signature of MO HealthNet participant.
(11)	Date of participant signature.
(12)	Reason participant is incapable of signing.
(13)	Signature of participant's representative.
(14)	Relationship of representative to participant. (Legal guardian, husband, etc.)
(15)	Date of representative's signature.