
# New York State Billing Guidelines

## CLINIC

Version 2011 - 01

6/1/2011


**eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.**

**eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. CSC is the eMedNY contractor and is responsible for its operation.**

**The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at www.emedny.org.**

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***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

# 1. Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Clinics and should be used by the provider as an instructional, as well as a reference tool.

# 2. Claims Submission

***Clinics can submit their claims to NYS Medicaid in electronic format only.***

## 2.1 Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

***eMedNY will process both 4010 and 5010 transaction types between July 21, 2011 and December 31, 2011. All Trading Partners will be required to employ the 5010 standards in accordance with federal mandates as of January 1, 2012.***

Clinic providers must use the HIPAA 837 Institutional (837I) transaction.

Direct billers should refer to the sources listed below in order to comply with the NYS Medicaid requirements.

- 5010 Implementation Guides (IGs) explain the proper use of 837I standards and other program specifications. These documents are available at store.X12.org.
- The eMedNY 5010 Companion Guide provides specific instructions on the NYS Medicaid requirements for the 837I transaction. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Transaction Information Standard Companion Guide.
- The NYS Medicaid Technical Supplementary CG provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are error report information and communication specifications. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Trading Partner Information Companion Guide.

Further information on the 5010 transaction is available at www.emedny.org by clicking: eMedNYHIPAASupport.

# 3. General Clinic Billing Procedures

The following information details billing instructions and related information for clinic claims in the following main categories:

- Utilization Threshold Program
- Medicaid Copayments
- Replacements/Voids of Previously Paid Claims
- Abortion/Sterilization Claims
- Secondary Billing
- Billing for Multiple Dates of Service on a Claim
- Procedure Codes
- Dental Clinics

## 3.1 Utilization Threshold (UT) Program

The UT Program places limits on the number of services a Medicaid member may receive in a benefit year. A benefit year is a 12-month period which begins the month the member becomes Medicaid eligible. The following service categories have member specific limitations:

- Clinic/physician visits
- Laboratory procedures
- Pharmacy items
- Mental health clinic visits
- Dental clinic visits

Clinic providers need to familiarize themselves with the Clinic Specialty Codes authorized by NYS Medicaid and on file for each provider. Some specialty codes are exempt from the UT Program.

When billing for services that are UT exempt, the provider must enter the Service Authorization Exception Code "7". The SA Exception Code is entered in the 837 Institutional claim in Loop 2300, REF02 of the Service Authorization Exception Code Segment.

Specialty Codes exempt from needing UT processing are located in Appendix A of this manual.

Detailed instructions and processing rules relative to the UT Program are available at www.emedny.org:Utilization Threshold Program.

# 3.2 Medicaid Copayments

Clinic claims are subject to a co-payment reduction in the amount of $3.00 unless the client or service is co-payment exempt. For more information, please refer to Information for All Providers, General Policy document which can be found at www.emedny.org by clicking: General Policy.

# 3.3 Replacements/Voids of Previously Paid Claims

If submitting an ***Adjustment (Replacement) or a Void*** to a previously paid claim, enter the ***Transaction Control Number (TCN)*** assigned to the claim to be adjusted or voided. The TCN is the claim identifier and is listed in the Remittance Advice. If a TCN is entered, the final position of the Type of Bill must be 7 or 8.

When submitting an original claim or the resubmission of a previously denied claim, this information is not to be entered on the claim as resubmissions are considered original claims by eMedNY. Adjustments and voids are ***not*** subject to Medicaid's 90 day timely filing policy.

Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

## 3.3.1Adjustments

An adjustment may be submitted to correct any information on a previously paid claim other than:

- The billing Provider ID
- The Member ID.

## 3.3.2Voids

A void is submitted to nullify the original claim in its entirety.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form.
- The void must contain the TCN and the originally submitted Billing Provider ID and Member ID.

***Note: Once a claim is voided, any rebilled claim is subject to the 90 day timely filing policy. Claims with a date of service over 6 years old cannot be adjusted or voided.***

# 3.4 Abortion/Sterilization Claims

When applicable, enter the appropriate Condition Code in loop 2300, HI segment, to indicate whether the service being claimed was related to an induced abortion or sterilization. The abortion/sterilization codes can be found in the NUBC UB-04 Manual.

When billing for procedures performed for the purpose of sterilization, a completed Sterilization Consent Form, LDSS-3134, is required and must be retained by the provider as proof the consent was properly obtained. (See Appendix A - Sterilization Consent Form – LDSS-3134 for instructions.)

# 3.5 Service Location Address

The address where services were performed is required in the 837 formats. It must be reported as either the billing provider's address (Loop 2010AA) or in the service location loop (2310E) at the claim level.

When reporting the billing provider and service location addresses, the full 9 digit ZIP Code is required. The 9 digit ZIP Code provided will be used to derive the Locator Code used in processing.

***NOTE: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct address updates, please refer to Information for All Providers, Inquiry section located at www.emedny.org by clicking:*** Inquiry.

# 3.6 Secondary Billing

## 3.6.1Medicare Primary

Medicare claims are identified by the Payer Code "MA" or "MB" reported in Loop 2320 SBR09 (Subscriber Information Segment). Enter all payment and adjustment information as provided in the Prior Payer Remittance Advice. To determine payment, eMedNY will process the information as appropriate.

## 3.6.2Medicare Managed Care Primary

Medicare Managed Care claims are identified by the Payer Code "16" reported in Loop 2320 SBR09 (Subscriber Information Segment). Enter all payment and adjustment information as provided in the Prior Payer Remittance Advice. To determine payment, eMedNY will process the information as appropriate.

## 3.6.3Non-Medicare Payer Primary

Payers identified by any other Payer Code than "16", "MA", or "MB" reported in Loop 2320 SBR09 (Subscriber Information Segment). Enter all payment and adjustment information as provided in the Prior Payer Remittance Advice. To determine payment, eMedNY will process the information as appropriate.

# 3.7 Billing for Multiple Date of Service on a Claim

The date(s) of service must be entered on the header level of the claim. The individual procedure date(s) of service are reported on the line with the applicable revenue code. The date(s) of service entered on the line must fall within the date range entered on the header.

Clinics are allowed to submit multiple dates of service when each date of service is represented by the same rate code.

# 3.8 Procedure Coding

All health care providers and plans must utilize the 2011 Healthcare Common Procedure Coding System (HCPCS) as released by the federal Centers for Medicare and Medicaid Services (CMS).

Other available coding resources include:

- ***HCPCS Level I*** (CPT-4) procedure codes for practitioners and laboratories can be purchased in hard copy or electronic format through many publishing houses.
- ***HCPCS Level II*** (Alpha-Numeric) codes for other medical services are available electronically at: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/
- ***ICD-9 Diagnosis and Procedure Codes*** are available electronically at: http://www.cms.hhs.gov/icd9providerdiagnosticcodes. The codes are also available through publishing houses.

HCPCS and ICD-9 codes are not Medicaid specific. Providers must use the current code set when billing any health care payer.

# 3.9 Dental Clinics

Dental clinic claims must contain a dental procedure code and the Revenue Code 0512.

# 4. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines.

# APPENDIX A
# STERILIZATION CONSENT FORM – LDSS-3134

A Sterilization Consent Form, LDSS-3134, must be completed for each sterilization procedure. A supply of these forms, available in English and in Spanish LDSS-3134(S)], can be obtained from the NYSDOH website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

***When claims include services for sterilization procedures, the provider must complete and retain a signed LDSS-3134 [or LDSS-3134(S)] form.***

When completing the LDSS-3134, please follow the guidelines below:

- An illegible or altered form is unacceptable and will cause a paper claim to deny
- Ensure that all five copies are legible.
- Each required field must be completed in order to ensure payment.
- If a woman is not Medicaid eligible at the time she signs the LDSS-3134 [or LDSS-3134(S)] form but becomes eligible prior to the procedure and is 21 years of age when the form was signed, the 30 day waiting period starts from the date the LDSS form was signed regardless of the date the woman becomes Medicaid eligible.

A sample Sterilization Consent Form and step-by-step instructions follow on the next pages.

**LDSS-3134** (2/01)

## STERILIZATION CONSENT FORM

| PATIENT NAME 1. | CHART NO. | RECIPIENT ID NO. |
|---|---|---|
| HOSPITAL/CLINIC | | |

**NOTICE**: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

### ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from 2. (doctor or clinic). When I asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a 3. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 4. (Month Day Year)

I, 5., hereby consent of my own free will to be sterilized by 6. (Doctor)

by a method called 7.. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

8. (Signature) Date: 9. (Month Day Year)

You are requested to supply the following information, but it is not required: 10.

*Race and ethnicity designation (please check)*

- ☐ 1 American Indian or Alaska Native
- ☐ 2 Asian or Pacific Islander
- ☐ 3 Black (not of Hispanic origin)
- ☐ 4 Hispanic
- ☐ 5 White (not of Hispanic origin)

### ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read 11. him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

12. (Interpreter) (Date)

### ■ STATEMENT OF PERSON OBTAINING CONSENT■

Before 13. (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation 14., the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowlingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15. (Signature of person obtaining consent) (Date)

16. (Facility)

17. (Address)

### ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 18. (Name of individual to be sterilized) on 19. (Date of sterilization) 20. (Operation), I explained to him/her the nature of the sterilization operation 21. (Specify type of operation), the fact that it is intended to be a final irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date sterilization was performed.

(2) This sterilization was preformed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable and fill in information requested): 22.

- ☐ 1. Premature delivery
  Individual's expected date of delivery: 23.
- ☐ 2. Emergency abdominal surgery: 24.

(describe circumstances ): 25.

26. (Physician) (Date)

**THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY -- WITNESS CERTIFICATION**

I, 27. do certify that on 28. I was present while the counselor read and explained the consent form to 29. (patient's name) and saw the patient sign the consent form in his/her handwriting.

| SIGNATURE OF WITNESS | TITLE | DATE |
|---|---|---|
| X 30. | 31. | 32. |

**REAFFIRMATION** (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form. I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

| SIGNATURE OF PATIENT | DATE | SIGNATURE OF WITNESS | DATE |
|---|---|---|---|
| X 33. | 34. | X 35. | 36. |

**DISTRIBUTION**: 1 – Medical Record File 2 – Hospital Claim 3- Surgeon Claim 4 – Anesthesiologist Claim 5 – Patient

CLINIC

# STERILIZATION CONSENT FORM – LDSS-3134 AND 3134(S) INSTRUCTIONS

## Patient Identification

### Field 1

Enter the patient's name, Medicaid ID number, and chart number.

The hospital or clinic name of is optional.

## Consent to Sterilization

### Field 2

Enter the name of the individual doctor or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (26) cannot obtain the consent.

### Field 3

Enter the name of sterilization procedure to be performed.

### Field 4

Enter the member's date of birth. Check to see that the member is at least 21 years old. If the member is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

### Field 5

Enter the member's name.

### Field 6

Enter the name of the doctor expected to perform the sterilization. It is understood this may not be the doctor who eventually performs the sterilization (26).

### Field 7

Enter the name of sterilization procedure.

### Field 8

The patient must sign the form.

### Field 9

Enter the date of member's signature. This is the date on which the consent was obtained.

The sterilization procedure must be performed no less than 30 days, nor more than 180 days, from this date.

Exceptions to the 30 day rule include:

- instances of premature delivery (23), or
- emergency abdominal surgery (24/25), when at least 72 hours (three days) have elapsed.

Except in instances of premature delivery (23), or emergency abdominal surgery (24/25) when at least 72 hours (three days) must have elapsed.

### Field 10

Completion of the race and ethnicity designation is optional.

## Interpreter's Statement

### Field 11

If the person to be sterilized does not understand the language of the consent form, the services of an interpreter will be required. Enter the language employed.

### Field 12

The interpreter must sign and date the form.

## Statement of Person Obtaining Consent

### Field 13

Enter the member's name.

### Field 14

Enter the name of the sterilization operation.

### Field 15

The person who obtained consent from the patient must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (26).

### Field 16

Enter the name of the facility with which the person who obtained the consent is associated. This may be a clinic, hospital, Midwife's, or physician's office.

### Field 17

Enter the address of the facility.

## Physician's Statement

The physician should complete and date this form after the sterilization procedure is performed.

### Field 18

Enter the member's name.

### Field 19

Enter the date the sterilization procedure was performed.

### Field 20

Enter the name of the sterilization procedure.

## Instructions for Use of Alternative Final Paragraphs

If the sterilization was performed at least 30 days from the date of consent (9), then cross out the second paragraph and sign (26) and date the consent form.

If less than 30 days but more than 72 hours has elapsed from the date of consent as a consequence of either premature delivery or emergency abdominal surgery, complete the following fields:

### Field 21

Specify the type of operation.

### Field 22

Select one of the check boxes as necessary.

### Field 23

If the sterilization was scheduled to be performed in conjunction with delivery but the delivery was premature, occurring within the 30-day waiting period, check box one (22) and enter the expected date of delivery (23).

## Field 24

If the patient was scheduled to be sterilized but within the 30-day waiting period required emergency abdominal surgery and the sterilization was performed at that time, then check box two (22) and describe the circumstances( 25).

## Field 25

Describe the circumstances of the emergency abdominal surgery.

## Field 26

The physician who performed the sterilization must sign and date the form.

The date of the physician's signature should indicate that the physician's statement was signed after the procedure was performed, that is, on the day of or a day subsequent to the sterilization.

**For Sterilizations Performed In New York City**

New York City local law requires the presence of a witness chosen by the patient when the patient consents to sterilization. In addition, upon admission for sterilization the patient is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

# Witness Certification

## Field 27

Enter the name of the witness.

## Field 28

Enter the date the witness observed the consent to sterilization. This date will be the same date of consent to sterilization (9).

## Field 29

Enter the patient's name.

## Field 30

The witness must sign the form.

## Field 31

Enter the title, if any, of the witness.

### Field 32

Enter the date of witness's signature.

## Reaffirmation

### Field 33

The member must sign the form.

### Field 34

Enter the date of the member's signature.  This date should be shortly prior to or same as date of sterilization in field 19.

### Field 35

The witness must sign the form for reaffirmation.  This witness need not be the same person whose signature appears in field 30.

### Field 36

Enter the date of witness's signature.

# APPENDIX B
# ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113, must be completed for each hysterectomy procedure. A supply of these forms, available in English and in Spanish, can be obtained from the New York State Department of Health's website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

***When claims include services for hysterectomy procedures, the provider must complete and retain a signed LDSS-3113 form***.

When completing the LDSS-3113, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable (will cause a paper claim to deny).
- Each required field or blank must be completed in order to ensure payment.

A sample Hysterectomy Consent Form and step-by-step instructions follow on the next pages.

**LDSS-3113** (4/84)

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
(NYS MEDICAID PROGRAM)

| 1. RECIPIENT ID NO. | 2. SURGEON'S NAME |
|---|---|
| | |

*EITHER PART I OR PART II MUST BE COMPLETED*

**Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION**

**RECIPIENT'S ACKNOWLEDGEMENT STATEMENT**

It has been explained to me, 3. _____ (RECIPIENT NAME), that the hysterectomy to be performed on me will make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me, and all my questions have been answered to my satisfaction prior to the surgery.

| 4. RECIPIENT OR REPRESENTATIVE SIGNATURE | 5. DATE | 6. INTERPRETER'S SIGNATURE (If required) | 7. DATE |
|---|---|---|---|
| X | | X | |

**SURGEON'S CERTIFICATION**

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

| 8. SURGEON'S SIGNATURE | 9. DATE |
|---|---|
| X | |

**Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION**

The hysterectomy performed on 10. _____ (RECIPIENT NAME) was solely for medical reasons. The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

☐ 11 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility)_____

_____

☐ 12 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)

_____

_____

☐ 13 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

| 14. SURGEON'S SIGNATURE | 15. DATE |
|---|---|
| X | |

**DISTRIBUTION:** File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient

# ACKNOWLEDGEMENT RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113 INSTRUCTIONS

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

## Field 1

Enter the Member ID number.

## Field 2

Enter the surgeon's name.

## Part I: Recipient's Acknowledgement Statement and Surgeon's Certification

This part must be signed and dated by the recipient or her representative unless one of the following situations exists:

- The recipient was sterile prior to performance of the hysterectomy;
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or
- The patient was not a Medicaid recipient on the day the hysterectomy was performed.

## Field 3

Enter the recipient's name.

## Field 4

The recipient or her representative must sign the form.

## Field 5

Enter the date of signature.

## Field 6

If applicable, the interpreter must sign the form.

### Field 7

If applicable, enter the date of interpreter's signature.

### Field 8

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

### Field 9

Enter the date of the surgeon's signature.

## Part II: Waiver of Acknowledgement

The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the member's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

### Field 10

Enter the member's name.

### Field 11

If the member's acknowledgment was ***not*** obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

### Field 12

If the member's Acknowledgment was ***not*** obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid member at the time the hysterectomy was performed.

### Field 13

If the member's Acknowledgment was ***not*** obtained because she was not a Medicaid member at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

## Field 14

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

## Field 15

Enter the date of the surgeon's signature.