

Ohio Department of Medicaid
**INSTRUCTIONS FOR COMPLETING ODM 03199,
 ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION**

In accordance with Title 42 Code of Federal Regulations (CFR) 441.251 and rule 5160-21-02.2 of the Ohio Administrative Code (OAC), for hysterectomy (surgical removal of the uterus) that is not performed for the sole purpose of sterilization, Medicaid payment may be made only when acknowledgment form ODM 03199 is completed and submitted. The form is available on the Ohio Department of Medicaid website, <http://www.medicaid.ohio.gov>.

All information entered on the acknowledgment form must be legible. Failure to submit a complete and legible form may delay payment or result in denial of the claim.

Section I must be completed for every patient.	
SECTION I: PATIENT INFORMATION	
1	Patient's Name This field shows the individual's legal name. The full surname (i.e., family name or "last" name) must be listed. An Initial may be used for the given name ("first" name) or a middle name, but the entire name must match the name on the claim.
2	Name of Patient's Representative (if any) <i>"Authorized representative" means a person, who is at least eighteen years old, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. If an individual has designated an authorized representative, all references to "individual" in regard to an individual's responsibilities include the individual's authorized representative.</i> —from OAC rule 5160:1-1-01
3	Patient's 12 Digit Medicaid Number This number is also referred to as the "Medicaid billing number," the "recipient ID number," or the "MMIS number." It must match the number on the claim.
4	Date of Hysterectomy This date must match the date of service on the claim.

Either Section II or Section III must be completed.

SECTION II: PROVISION OF HYSTERECTOMY INFORMATION PRIOR TO HYSTERECTOMY PROCEDURE(S)	
5	Patient/Representative Signature The mark entered in this field must be the legal signature of the individual identified in Field 1 or 2.
6	Date of [Patient/Representative] Signature This date (month, day, and year) can be no earlier than the individual's 21st birthday.
7	Name of Person Providing Information This field shows the name of the doctor or clinic staff member who informed the patient, both orally and in writing, that the procedure would make her incapable of reproducing (sterile).

8	Signature of Person Providing Information The mark entered in this field must be the legal signature of the individual identified in Field 7.
9	Date of Signature [of the Person Providing Information] This date (month, day, and year) corresponds to the signature in Field 8.

SECTION III: PHYSICIAN CERTIFICATION OF REASON FOR NOT PROVIDING HYSTERECTOMY INFORMATION PRIOR TO PROCEDURE	
10	[Option A: The individual was already sterile.] If this option applies, indicate a reason and a brief explanation of the cause of sterility must be given.
11	[Option B: The procedure was performed in an emergency in which provision of information was not possible.] If this option applies, indicate a reason and a brief description of the emergency must be given.
12	Name of the Physician Who Performed the Hysterectomy An Initial may be used for the given name ("first" name) or a middle name, but the entire name must match the name on the claim.
13	Signature of the Physician Who Performed the Hysterectomy The mark entered in this field must be the legal signature of the individual identified in Field 12.
14	Date of [Physician's] Signature This date (month, day, and year) corresponds to the signature in Field 13 and must not be earlier than the date on which the hysterectomy was performed.