wisconsin Medicaid update and BadgerCare

January 2003 ● No. 2003-07
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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Family Planning Clinics

Federally Qualified Health Centers

Physician Assistants

Physician Clinics

Physicians

Rural Health Clinics

HMOs and Other Managed Care Programs

Wisconsin Medicaid revises selected forms for physician services

Wisconsin Medicaid has revised selected forms for physician services. Providers are encouraged to discontinue using old versions of the forms and begin using the new forms. The revised forms include:

- Sterilization Informed Consent form and completion instructions.
- Abortion Certification Statements form.
- Acknowledgement of Receipt of Hysterectomy Information form.
- Second Opinion Elective Surgery Request / Physician Report form.

Revised forms

Wisconsin Medicaid has revised selected forms for physician services. The basic information requested on the forms has not changed; only the format of the forms has changed.

The revised forms and completion instructions, which may be photocopied for future use, are included in Attachments 1-5 of this *Wisconsin Medicaid and BadgerCare Update*.

Mandatory Sterilization Informed Consent form and instructions

The Sterilization Informed Consent form and completion instructions have been revised. The use of the Sterilization Informed Consent form is mandatory in order for Wisconsin Medicaid to reimburse providers for sterilization services. Providers should refer to the following attachments for the form and instructions:

- Attachment 1: Sterilization Informed Consent form completion instructions and a sample of the form that corresponds with the instructions, HCF 1164A, dated 01/03.
- Attachment 2: Sterilization Informed Consent form, HCF 1164, dated 01/03.

Voluntary forms

Wisconsin Medicaid encourages providers to discontinue using old versions of the forms and begin using the revised forms. The following attachments include the following voluntary forms:

- Attachment 3: Abortion Certification Statements, HCF 1161, dated 01/03.
- Attachment 4: Acknowledgement of Receipt of Hysterectomy Information, HCF 1160, dated 01/03.
- Attachment 5: Second Opinion Elective Surgery Request / Physician Report, HCF 1163, dated 01/03.

Acknowledgement of Receipt of Hysterectomy Information

Physicians are no longer required to sign and date the Acknowledgement of Receipt of Hysterectomy Information form. This change is consistent with HFS 107.06(3)(b) and (c), Wis. Admin. Code, which does not specify that physicians must sign the form.

Obtaining copies of the revised forms

The revised forms are also available in a fillable Portable Document Format (PDF) from the forms section of the Wisconsin Medicaid Web site. To get to this section, go to *www.dhfs.state.wi.us/medicaid/*. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu. Then choose "Provider Forms" from the "Provider Publications and Forms" topic area.
The fillable PDFs may be accessed using Adobe Acrobat Reader®* and completed electronically. To use a fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the revised forms, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers above.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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*The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT 1
Sterilization Informed Consent Completion Instructions and Sample

(The "Sterilization Informed Consent Completion Instructions" and a sample of the form that corresponds with the instructions are located on the following pages.)

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT FORM INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Wisconsin Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is mandatory in order for Wisconsin Medicaid to reimburse providers for services. Any corrections to the form must be signed by the physician and/or recipient, as appropriate. The use of opaque correction fluids on the Sterilization Informed Consent form is prohibited. Instead, strike the incorrect information and initial the corrected information.

CONSENT TO STERILIZATION

The person who obtains the informed consent must provide orally all of the requirements for the informed consent as listed on the consent form, must offer to answer any questions, and must provide a copy of the consent form to the recipient to be sterilized for consideration during the waiting period. (The person obtaining consent need not be the physician performing the procedure.)

Suitable arrangements must be made to ensure that the required information is effectively communicated to the recipient to be sterilized if he or she is blind, deaf, or otherwise handicapped.

Element 1 — Doctor or Clinic (required)
The physician named in Element 1 is not required to match Elements 5 or 23. A recipient may receive information from one doctor/clinic and be sterilized by another. Corrections to this field must be initialed by the person obtaining consent or the physician.

Element 2 — Procedure (required)
The information given in Element 2 must be comparable, but not necessarily identical, to Elements 6, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Element 3 — Date of Birth (required)
Recipient's date of birth. The month, day, and year must be clearly indicated. Corrections to this field must be lined through and initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 4 — Name of Recipient (required)
The recipient's name must be legible. ***Initials are acceptable for the first and/or middle name only.*** The name may be typed. If this element does not match the signature in Element 7, check the Eligibility Verification System (EVS) to verify that this is the same person. Consider the name in Element 4 to be the valid name. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 5 — Doctor (required)
The name of the doctor, affiliates, or associates is acceptable. The physician in Element 5 is not required to match Element 1 or 23. Corrections to this element must be initialed by the person obtaining consent or the physician. (A consent form *is* transferable and does ***not*** necessitate a new 30-day waiting period.)

Element 6 — Procedure (required)
The information given in Element 6 must be comparable, but not necessarily identical to Elements 2, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Element 7 — Signature (required)
The recipient's signature does not need to ***exactly*** match the name in Element 4. It is unacceptable for the recipient's signature to be ***completely*** different from the name in Element 4. Initials are acceptable for the first and/or middle name. An "X" is acceptable as a signature *if* a witness of the recipient's choice has signed the form. The individual obtaining consent may not act as a witness. There is no field on the form for a witness' signature; it should appear directly below the recipient signature element and be followed by the date of witness, which must match the recipient's signature date in Element 8. Corrections to Element 7 must be initialed by the recipient. (A correction does ***not*** require a new 30-day waiting period.)

Element 8 — Date (required)
The recipient must be at least 21 years old on this date. If the signature date is the recipient's 21st birthday, the claim is acceptable. At least 30 days but not more than 180 days, excluding the consent and surgery dates, must have passed between the date of the written informed consent and the date of sterilization, except in the case of premature delivery. Corrections to this field must be initialed by the recipient. (A correction does ***not*** require a new 30-day waiting period.)

Element 9 — Race and Ethnic Designation (not required)

INTERPRETER'S STATEMENT

An interpreter must be provided to assist the recipient if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent.

Elements 10 to 12 — Language, Interpreter, Date
If applicable, the date the interpreter signs can be on or prior to the recipient's signature date in Element 8.

STATEMENT OF PERSON OBTAINING CONSENT

Element 13 — Name of Recipient (required)
The recipient's name does not need to ***exactly*** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 14 — Procedure (required)
The information given in Element 14 must be comparable, but not necessarily identical, to Elements 2, 6, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Elements 15 to 18 — Signature of Person Obtaining Consent, Date, Facility, Address (required)
The person obtaining the consent may be, but is not required to be, the physician performing the procedure. A facility and/or facility address must be indicated, but only one (of the provider's choice) is required. Additionally, the signature date (Element 16) can be prior to, on, or after the date the recipient signs (Element 8). Corrections to this field must be initialed by the person obtaining consent.

PHYSICIAN'S STATEMENT

Element 19 — Name of recipient (required)
The recipient's name does not need to ***exactly*** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This does ***not*** require a new 30-day waiting period.)

Element 20 — Date of sterilization (required)
The date must match the date of service (DOS) on the claim. Reimbursement is not allowed unless at least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of the sterilization. This means the DOS must be at least the 31st day after the recipient signature date and no later than the 181st day after that date. Neither the date of informed consent nor the date of surgery will be counted as part of the 30-day requirement. In cases of premature delivery, the consent form must have been signed at least 30 days prior to the expected date of delivery as identified in Element 22 and at least 72 hours must have passed before premature delivery. In cases of emergency abdominal surgery, at least 72 hours must have passed from the date the recipient gave informed consent to be sterilized. Element 22 must be completed in the case of premature delivery or emergency abdominal surgery. Corrections to this field must be initialed by the physician.

Note: Element 20 extends to the next line on the form.

Element 21 — Specify type of operation (required)
Must be comparable to Elements 2, 6, and 14 or state "same." If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 22 — Exception to 30-Day Requirement (required if less than 31 days have passed between date of signed consent and sterilization date)
The individual's expected date of delivery must be stated in the case of premature delivery. In the case of emergency abdominal surgery, the circumstances must be described. Corrections to this field must be initialed by the physician.

Element 23 — Physician Signature and Date (required)
- Alterations to this field must be initialed by the physician.
- Initials may be used in the signature for the first and/or middle name only.
- A signature stamp or computer-generated signature is not acceptable.
- The physician's signature on the consent form does not need to exactly match the ***performing*** physician's name on the claim form. It is unacceptable for the physician's signature to be completely different from the name on the claim.
- Physician's signature date must be on or after the date the sterilization was performed.
- A nurse or other individual's signature is not acceptable.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1164A (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(3)(e), Wis. Admin. Code

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT

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 **1** (doctor or clinic). When I first 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 AFDC 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 known as a/an **2**. The discomforts, risks and benefits associated with the operation have been explained to me. All of 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 **3** (Month Day Year).

I, **4**, hereby consent of my own free will to be sterilized by **5** (doctor) by a method called **6**. 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.

7 Date **8**
SIGNATURE *— Recipient* *Month Day Year*

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

Race and ethnicity designation (please check)

9
- ❑ American Indian or Alaska native
- ❑ Asian or Pacific Islander
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ 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 him/her the consent form in **10** language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 **12**
SIGNATURE *— Interpreter* *Date Signed*

■ 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 knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15 **16**
SIGNATURE *— Person Obtaining Consent* *Date Signed*

17
Facility

18
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon **19** (Name of individual to be sterilized) on **20** (Date of sterilization), 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 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 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 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 the sterilization was performed.

(2) This sterilization was performed 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 box and fill in information requested):

22
- ❑ Premature delivery
- ❑ Individual's expected date of delivery: _____
- ❑ Emergency abdominal surgery:

(describe circumstances): _____

_____

23
SIGNATURE *— Physician* *Date Signed*

ATTACHMENT 2
Sterilization Informed Consent

(A copy of the "Sterilization Informed Consent" form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1164 (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(3)(e), Wis. Admin. Code

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT

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 _____. When I first asked for the
(doctor or clinic)
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 AFDC 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 known as a/an _____. The discomforts, risks and benefits associated with the operation have been explained to me. All of 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 _____.
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____by
(doctor)
a method called _____. 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.

_____ Date_____
SIGNATURE *— Recipient* *Month Day Year*

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

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ 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 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.

_____
SIGNATURE *— Interpreter* *Date Signed*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the consent form,
name of individual
I explained to him/her the nature of the sterilization operation _____, 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 knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
SIGNATURE *— Person Obtaining Consent* *Date Signed*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____
Name of individual to be sterilized *Date of sterilization*
_____, I explained to him/her the nature of the sterilization
operation
operation _____, the fact that it is intended
specify type of operation
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 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 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 the sterilization was performed.

(2) This sterilization was performed 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 box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery:

(describe circumstances): _____

_____
SIGNATURE *— Physician* *Date Signed*

Reset Form

ATTACHMENT 3
Abortion Certification Statements

(A copy of the "Abortion Certification Statements" form is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1161 (Rev. 01/03)

STATE OF WISCONSIN
Section 20.927, Wis. Stats.

WISCONSIN MEDICAID
ABORTION CERTIFICATION STATEMENTS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Coverage Policy
In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred, ***and*** provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.

INSTRUCTIONS: When filing a claim for reimbursement of an abortion with Wisconsin Medicaid, physicians must attach a written certification statement attesting to one of the circumstances below. The following are sample certification statements that providers may use to certify the medical necessity of the abortion. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

I. LIFE OF THE MOTHER

I, _____ , certify that
(Name — Provider)

on the basis of my best clinical judgement, abortion is directly and medically necessary to save the life of

_____ , of
(Name — Recipient)

_____ ,
(Address — Recipient)

for the following reasons:

_____ .

_____ _____
SIGNATURE — Physician Date Signed

SECTION II — VICTIM OF RAPE OR INCEST

I, _____ , certify that it is my belief that
(Name — Provider)

_____ , of
(Name — Recipient)

_____ , was the victim of rape (or incest).
(Address — Recipient)

_____ _____
SIGNATURE — Physician Date Signed

SECTION III — GRAVE AND LONG-LASTING DAMAGE TO PHYSICAL HEALTH

I, _____, certify on the basis of
(Name — Provider)

my best clinical judgement that due to an existing medical condition grave, long-lasting physical health damage to

_____ , of
(Name — Recipient)

_____ ,
(Address — Recipient)

would result if the pregnancy were carried to term. The following medical condition necessitates the abortion (specify the medical condition/diagnosis):

_____

_____ _____
SIGNATURE — Physician Date Signed

Reset Form

ATTACHMENT 4
Acknowledgement of Receipt of Hysterectomy Information

(A copy of the "Acknowledgement of Receipt of Hysterectomy Information" form is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing HFS 107.06(3)(c), Wis. Admin. Code
HCF 1160 (Rev. 01/03)

WISCONSIN MEDICAID
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: The Acknowledgement of Receipt of Hysterectomy Information form is to be completed by a physician before performing the surgery and attached to the CMS 1500 claim form. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

Medicaid reimbursement for a hysterectomy requires both a second surgical opinion and the completion of this form or similar form with the same information. This form is not to be used for purposes of consent of sterilization. A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form.

Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. The name in this element must match the name on the claim.

Address — Recipient
Enter the recipient's address. Use the EVS to obtain the address.

Recipient's Medicaid ID No.
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. This identification number must match the identification number on the claim.

Name — Physician
Enter the performing provider's name.

Physician's Medicaid Provider No.
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

Name — Recipient
Enter the recipient's name. The name in this element must match the recipient's name entered at the top of the form.

Signatures — Recipient, Representative, and Interpreter
Recipient — The recipient must sign and date this element. (Signing this form does not require the recipient to undergo the hysterectomy surgery.)

Representative — The representative must sign and date this element if a representative was required for the recipient.

Interpreter — An interpreter must sign and date this element if the recipient does not understand the language used on the form and if an interpreter was used to translate this information.

Date Signed
Enter the date the recipient signs the Acknowledgement of Receipt of Hysterectomy Information form in this element. This date must be ***on or before*** the date of service on the claim.

WISCONSIN MEDICAID

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Name — Recipient		Address — Recipient
Recipient's Medicaid ID No.	Name — Physician	Physician's Medicaid Provider No.

It has been explained to _____ that the hysterectomy to be
(Name — Recipient)

performed on her (me) will render her (me) permanently incapable of reproducing.

SIGNATURES — Recipient, Representative, and Interpreter

Recipient

Representative

Interpreter

Date Signed

Reset Form

ATTACHMENT 5
Second Opinion Elective Surgery Request / Physician Report form

(A copy of the "Second Opinion Elective Surgery Request / Physician Report" form is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1163 (Rev. 01/03)

WISCONSIN MEDICAID
SECOND OPINION ELECTIVE SURGERY REQUEST / PHYSICIAN REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: All Medicaid recipients, with the exception of recipients enrolled in a Medicaid HMO or in emergent, urgent, or waiver situations, are required to obtain a second surgical opinion (SSO) before having one of the surgical procedures listed in the Medicine and Surgery section of the Physician Services Handbook on an elective basis.

The ultimate responsibility for the decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second opinion physician agrees or disagrees with the recommending surgeon.

SECTION I — RECOMMENDING SURGEON INFORMATION

Date (MM/DD/YY)

Note: The recommending surgeon must complete Section I of the form before sending the form to the second opinion physician.

Check One
- ❑ I would like the second opinion physician to send this form back to me.
- ❑ I would like the second opinion physician to send this form directly to Wisconsin Medicaid.

Recipient (Patient) Information

Name — Recipient	Wisconsin Medicaid Identification Number (10 digits)	
Address (Street / P.O. Box)		
City	State	Zip Code
Telephone Number	County	
Birth Date (MM/DD/YY)	Gender ❑ Female ❑ Male	

Recommending Surgeon (mailing address)

Name — Recommending Surgeon	Wisconsin Medicaid Provider Number (eight digits)	
Address (Street)		
City	State	Zip Code
Telephone Number		

Specify whether someone other than the recipient (parent, relative, guardian, etc.) should be contacted concerning the second opinion.

Name — Contact Person	Telephone Number

Address (Street)

City	State	Zip Code

Primary / Referring Physician (if different from above)

Name — Primary / Referring Physician

Address (Street)

City	State	Zip Code

Check Proposed Procedure

- ❑ Cataract extraction and/or intraocular lens implant (❑ check if bilateral)
- ❑ Cholecystectomy
- ❑ D&C (diagnostic)
- ❑ Hemorrhoidectomy
- ❑ Hernia repair (❑ check if bilateral)
- ❑ Hysterectomy
- ❑ Joint replacement — hip (❑ check if bilateral)
- ❑ Joint replacement — knee (❑ check if bilateral)
- ❑ Tonsillectomy and/or adenoidectomy
- ❑ Varicose vein surgery

SIGNATURE — Recommending Surgeon	Date Signed

SECTION II — SECOND OPINION PHYSICIAN INFORMATION

Note: The physician performing the second opinion must complete this section of the form.

Name — Performing Physician	Wisconsin Medicaid Provider Number (eight digits)

Address (Street)

City	State	Zip Code

Findings (include any information on alternative treatment, additional medical tests, or other significant findings)

❑ These findings and options / alternatives were presented to the recipient.

Check One
- ❑ I agree with the need for the surgery.
- ❑ I do not agree with the need for the surgery.

Comments

SIGNATURE — Second Opinion Physician	Date Signed

Distribution: Following the recommending surgeon's request indicated on the front page, return this form to either the recommending surgeon whose name and address are listed on the front page, or mail to:

Wisconsin Medicaid
SSO Dept
6406 Bridge Rd
Madison WI 53784-0012

Reset Form