Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

HYSTERECTOMY INFORMATION FORM

Name of physician _____ Name of patient _____
(Please print) (Please print)

Instructions to Providers—Each provider requesting payment for any portion of a hysterectomy must complete and attach this Hysterectomy Information (HI-1) form to the claim form. When more than one provider is requesting payment for the same hysterectomy, a photocopy of the completed form may be submitted in place of the original. Consent forms can be downloaded from Mass.gov at mass.gov/lists/masshealth-provider-forms-used-by-multiple-provider-types. The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

A. HYSTERECTOMY INFORMATION

A hysterectomy is an operation in which a patient's uterus (womb) is removed. A hysterectomy should be done only when there is a disease or injury of the uterus (or some other medical problem) that can be treated only by removing the uterus. Your doctor should explain to you why a hysterectomy is needed and what discomforts, risks, and benefits may result from the surgery.

If you have a hysterectomy, you can't become pregnant or bear children. A hysterectomy is permanent and can't be reversed.

MassHealth will not pay for a hysterectomy if the purpose is for birth control. If the reason that you're having a hysterectomy is to avoid bearing children, you should consider other methods of sterilization, such as tubal ligation (having your tubes tied). A hysterectomy takes much longer than a tubal ligation, and you'd be in the hospital longer. There's more discomfort and a greater chance of serious health problems with a hysterectomy.

B. MEMBER'S ACKNOWLEDGEMENT THAT HYSTERECTOMY INFORMATION WAS RECEIVED

Federal regulations (42 CFR 441.255) require that a MassHealth member having a hysterectomy sign a written acknowledgement that information about hysterectomies was received before the operation was performed. The following can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Acknowledgement That Hysterectomy Information Was Received

I have read the information above about the hysterectomy. A medical provider has also explained hysterectomies to me. The discomfort, risks, and benefits that go along with a hysterectomy have been explained to me. All of my questions have been answered to my satisfaction.

I understand that if I have a hysterectomy, I can't become pregnant or bear children. I understand that a hysterectomy is permanent and can't be reversed.

_____ _____ _____
Signature of member or representative | Date | Relationship of representative to member

Name of physician _____ (Please print)

Name of patient _____ (Please print)

C. PHYSICIAN'S CERTIFICATION

Federal regulations (42 CFR 441.255) don't require the patient's prior acknowledgement when the patient was sterile before the hysterectomy or in the case of emergency surgery. In such cases, the physician who performed the hysterectomy must certify in writing that one of the following circumstances existed at the time of the surgery.

By signing any physician certifications, the physician certifies under the pains and penalties of perjury that the information and any attached statement that the physician has provided has been reviewed and signed by the physician, and is true, accurate, and complete to the best of the physician's knowledge. The following can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Check the appropriate box below if any of the following circumstances is applicable, and complete only that section of the form.

☐ 1. Prior Sterility

I certify that the above-named member was sterile before the hysterectomy and that the cause of sterility was the following.

_____

_____

☐ 2. Emergency Surgery

I certify that because of a life-threatening emergency, it wasn't possible to acquire the acknowledgement of the above-named member before the hysterectomy. The nature of the emergency was the following.

_____

_____

_____ _____ _____

Date of hysterectomy | Signature of physician who performed hysterectomy | Date signed

D. PHYSICIAN'S CERTIFICATION FOR RETROACTIVE ELIGIBILITY

Check the appropriate box below if any of the following circumstances is applicable and complete only that section of the form.

By signing any physician certifications, the physician certifies under the pains and penalties of perjury that the information and any attached statement that the physician has provided has been reviewed and signed by the physician, and is true, accurate, and complete to the best of the physician's knowledge.

☐ 1. Retroactive Eligibility: Informed Member

The above-named patient was not a MassHealth member on the date on which the hysterectomy was performed. However, I informed the patient before surgery that the operation would make them sterile.

☐ 2. Retroactive Eligibility: Prior Sterility

The above-named patient was not a MassHealth member on the date on which the hysterectomy was performed. However, I certify that the patient was sterile before the hysterectomy and that the cause of sterility was the following.

_____

_____

☐ 3. Retroactive Eligibility: Emergency Surgery

The above-named patient was not a MassHealth member on the date on which the hysterectomy was performed. However, I certify that because of a life-threatening emergency, it wasn't possible to acquire the patient's acknowledgement before the hysterectomy. The nature of the emergency was the following.

_____

_____

_____ _____ _____

Date of hysterectomy | Signature of physician who performed hysterectomy | Date signed

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