

## **Hysterectomy and Sterilization Procedures and Consent Forms**

### **HYSTERECTOMY RECEIPT OF INFORMATION FORM FD-189**

Federally prescribed documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form (FD-189). Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involving hysterectomy procedures must have a properly completed FD-189 attached when submitted for payment. Hysterectomy claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing hysterectomy procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with your manual.

Providers may obtain additional copies of the FD-189 form from the Fiscal Agent; however, photocopies of the FD-189 are acceptable.

A sample of the Hysterectomy Receipt of Information Form and instructions for the form's proper completion are included for reference.

**State of New Jersey  
Department of Human Services  
Division of Medical Assistance  
and Health Services**

**HYSTERECTOMY RECEIPT OF INFORMATION FORM**

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You cannot have a baby after your uterus is removed and you will not have menstrual periods anymore.

I received the above information orally and in writing from \_\_\_\_\_  
*name of clinic or*  
\_\_\_\_\_ before my operation was performed.  
*physician*

I talked to \_\_\_\_\_ about a hysterectomy. \_\_\_\_\_  
*name of responsible person(s)* *she/he/they*  
discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by \_\_\_\_\_ of \_\_\_\_\_ and that  
*name of staff Member* *clinic/hospital/physician*  
all my questions were answered to my satisfaction.

I, \_\_\_\_\_, hereby consent (or did consent) of my own free  
*name of recipient*  
will to have a hysterectomy done by \_\_\_\_\_ and/or  
*physician*  
associate(s) or assistant(s) of his or her choice.

I consent (or did consent) to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department but only for purposes of determining if Federal laws were observed.

\_\_\_\_\_  
**Recipient's Signature**

\_\_\_\_\_  
**Date: Month/Day/Year**

**Item-By-Item Instructions for Completing the  
Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)**

- 1) ***Name of Clinic or Physician:*** Enter the name of the clinic or physician who provided the information.
- 2) ***Name of Responsible Person(s):*** Enter the name of the individual who discussed the procedure with the recipient.
- 3) ***She/He/They:*** Enter appropriate selection.
- 4) ***Name of Staff Member:*** Enter the name of the individual who explained the procedure to the recipient.
- 5) ***Clinic/Hospital/Physician:*** Enter the name of the clinic/hospital or physician's office in which the individual who explained the procedure is affiliated.
- 6) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.
- 7) ***Name of Physician:*** Enter the physician's name.
- 8) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date the completed form.