IAMHP
ILLINOIS ASSOCIATION OF MEDICAID HEALTH PLANS

All Medicaid MCOs require the HFS 1977 Hysterectomy Acknowledgement form or the Sterilization form 2189.

The appropriate form must be completed fully and accurately prior to a hysterectomy or sterilization being performed on a Medicaid member. A form is not considered complete if it is not signed and dated appropriately by both the member and the physician.

IAMHP and its member plans have prepared a brief summary and highlighted areas where common mistakes are made for the **HFS 1977 form**:

> **Part I** must be completed in its entirety. The provider number is the Medicaid provider ID number. If Part I is not complete a provider may face a claim denial.
>
> **Parts II and III** must be signed and dated by the patient and physician no later than the date of the surgery. The purpose of the HFS 1977 hysterectomy acknowledgement form is to ensure members are informed of the effects of a hysterectomy prior the surgery. Additionally, the physician signature is needed to ensure appropriate clinical review.
>
> **Part IV**, if applicable, must be signed and dated in addition to providing the appropriate detail regarding the exception.

IAMHP and its member plans have prepared a brief summary and highlighted areas where common mistakes are made for the **HFS 2189 form:**

> **Consent to Sterilization** must be completed and signed by the Medicaid member prior to treatment. Race and ethnicity information is requested but not required.
>
> **Interpreter statement** must be completed and signed if an interpreter was used. The date should be prior to treatment.
>
> **Statement of person obtaining consent** must be completed and signed prior to treatment. If the information is completed but there is not a signature the form is not complete. The signature may not be provided at a later date.
>
> **Physician statement** must be completed and signed prior to treatment. Additionally, please **cross out** paragraph 1 or 2, whichever is **NOT** used. If a physician circles a section that is used the form has not been completed accurately. If the information is completed but there is not a signature the form is not complete. The signature may not be provided at a later date.

HFS 1977 Hysterectomy Acknowledgement Form

Helpful Hints_Form Must Be Completed In Its Entirety

State of Illinois
Department of Healthcare and Family Services

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART I - (MUST BE COMPLETED)

Recipient Name _____

Recipient Identification No. _____ Provider No. _____

Physician Name _____ NPI No. _____

PART II - ACKNOWLEDGEMENT

It has been explained to _____
and the patient's representative, if any, orally and in writing that the hysterectomy to be performed on the patient will render the patient permanently incapable of reproducing.

_____ _____
Recipient or Representative Signature Date:

_____ _____
(If required, Interpreter Signature) Date:

PART III - PHYSICIAN STATEMENT

In my professional judgment, the hysterectomy is not being performed solely to accomplish sterilization; it is being performed for other medically necessary reasons.

_____ _____
Physician Signature Date:

PART IV - EXCEPTION REQUEST

- Exception 1 - I certify that the above named individual was already sterile at the time of the hysterectomy. The cause of the sterility was _____
- Exception 2 - I certify that the hysterectomy performed on the above named individual was performed under a life threatening emergency situation,
  i.e. _____
  in which I determined prior acknowledgment of receipt of hysterectomy information was not possible. I have attached a copy of the hospital operative record or other written explanation as to the nature of the emergency.
- Exception 3 - The above named individual had a hysterectomy performed during a period of retroactive Medicaid eligibility. Date of Surgery _____

I certify that the above named individual was informed prior to the operation that the hysterectomy would render the patient permanently incapable of reproducing; or that Exception 1 ☐ or that Exception 2 ☐ as certified above, made such explanation unnecessary or impossible.

_____ _____
Physician Signature Date:

Completion mandatory, 305 ILCS 5/1-1 et seq., penalty non-payment.
Form approved by the Forms Management Center.

HFS 1977(R-12-09)

Part I MUST be completed in its entirety or is subject to a claim denial. (The Provider No. is the Provider's Medicaid ID #.)

Part IV – Please fill out as applicable, sign and date

Sterilization Form 2189 Provider Tip Sheet

This form must be completed in its entirety or will be subject to a claim denial. Please remember to choose and complete fields (1) or (2) under the Physician's Statement. Without completing, the claim will be subject to a claim denial.

IHFS Illinois Department of Healthcare and Family Services

NOTICE: YOUR DECISION AT ANY TIME 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 _____ (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 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 known as a _____.

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

_____ (Doctor)

by 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 and Human Services 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.

_____ (Signature) Date _____ (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.

_____ (Interpreter) _____ (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual) signed the consent form, 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 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 of person obtaining consent) _____ (Date)

_____ (Facility)

_____ (Address)

■ PHYSICIAN'S STATEMENT ■

Completion Mandatory, 305 ILCS 5/1-1 et seq., penalty non-payment.

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization operation),

I explained to him/her the nature of the sterilization operation _____ (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 appears to understand the nature and consequence 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 30 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 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):

_____

_____ (Physician) _____ (Date)

HFS 2189 (R-7-06) IL478-1071

Completion of this form or compliance with instructions is voluntary, however, failure to do so may affect this Department's action. Form approved by Forms Management Center.