Maryland
DEPARTMENT OF HEALTH

Maryland Medical Assistance Program
Certificate for Abortion (MDH 521)

The Certification for Abortion (MDH 521) form must be completed by the physician performing the procedure and kept in the patient's Medical Record.*

Part I. Demographics

Patient Name: _____ Patient Medicaid #: _____

Patient Address: _____

Physician Name: _____ Date of Service: _____

Physician NPI #: _____ Place of Service:_____

Part II. Please choose from <u>one</u> of the following certifying criteria: 1, 2 or 3.

1. **Abortion was necessary because of the potential endangerment to the health of the patient/woman (For this criteria choose which description <u>best describes</u> the medical certification - A, B or C).**

   ❑ A. I certify that this abortion is necessary because, based on my professional judgement, continuation of the pregnancy is likely to result in death of the woman.

   Date: _____ Physician's signature:_____

   ❑ B. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, termination of pregnancy is medically necessary because there is substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical (somatic) health.

   Date: _____ Physician's signature:_____

   ❑ C. I certify that, in my professional judgement, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health.

Date: _____ Physician's signature:_____

2. **Abortion was neccessary because of serious genetic defects, deformities, or abnormalities to the fetus.**

   ❑ I certify that, within a reasonable degree of medical certainty, based on my professional judgement, this abortion is necessary because the fetus is affected by a genetic defect or serious deformity or abnormality.

   Date: _____ Physician's signature:_____

3. **Abortion was neccessary for a woman where the pregnancy was reported as a result of rape or incest. (<u>Complete both boxes A & B</u>)**

   ❑ A. I certify that this procedure is necessary for a victim of rape, sexual offense, or incest, and the incident has been reported to a law enforcment agency or to a public health or social agency.

   Date: _____ Physician's signature:_____

   ❑ B. Attached is a document submitted by an official of a law enforcement agency or public health service where the rape or incest was reported. The document includes the following information:
   1. Name and address of victim;
   2. Name and address of person making the report (if different from the victim);
   3. Date of the rape or incest incident;
   4. Date of the report (may not exceed 60 days after the incident);
   5. Statement that the report was signed by the person making it; and
   6. Name and signature of person at law enforcement agency or public health service who took the rape or incest report.

   Date: _____ Physician's signature:_____

*Providers must complete t**he Certification for Abortion (MDH-521) form and keep it in the patient's medical record. Providers must make the MDH 521 form available upon request.** Providers are **<u>not</u>** required to submit the MDH 521 with the claim. Instead, providers must indicate the appropriate two-character alpha condition code in Block 10d of the claim form. For complete information regarding billing codes and procedures, please refer to the CMS-1500 Billing Instructions at health.maryland.gov/providerinfo.

Maryland
DEPARTMENT OF HEALTH

MARYLAND MEDICAL ASSISTANCE PROGRAM
DOCUMENT for HYSTERECTOMY/ACKNOWLEDGEMENT FORM AND INSTRUCTIONS
(MDH 2990)
See the end of this form for instructions on completing and submitting the form.

Recipient's Name: _____ **Medicaid ID #:** _____

Date of Hysterectomy Procedure: _____

Complete **Part I and II** if the recipient is not sterile, is premenopausal, and the hysterectomy is not an emergency procedure.

Complete **Part III** if the recipient is sterile or postmenopausal, if the hysterectomy is an emergency procedure, or for retroactive eligibility.

PART I

Recipient or Guardian/Representative Acknowledgement Statement

I acknowledge that I have been advised orally and in writing, prior to the surgery, that a hysterectomy will render me permanently incapable of becoming pregnant and having children and that I have agreed to this surgery. The indication for the hysterectomy, along with the risks and benefits associated with the surgery, has been explained to me and all my questions have been answered prior to the surgery.

_____	_____	_____
Recipient or Guardian/Representative Name	Recipient or Guardian/Representative Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date
_____	_____	_____
Interpreter Name	Interpreter Signature	Date

PART II

Physician Certification Regarding Hysterectomy

I certify the hysterectomy is medically necessary due to the diagnosis _____, ICD-10 diagnosis code _____, and is not performed solely for the purpose of sterilization. Prior to the hysterectomy, the recipient and her authorized representative, if any, were informed orally and in writing that the recipient would be permanently incapable of reproducing as a result of this hysterectomy.

_____	_____	_____	_____
Physician Name	Physician Signature	Physician NPI #	Date

PART III

Waiver of Acknowledgement and Physician Certification

The hysterectomy performed on the above recipient was solely for medical indications and was not for the purpose of sterilization. Check the appropriate box(es) below.

1. The recipient was sterile or postmenopausal at the time of the hysterectomy. Please document the diagnosis of sterility or postmenopausal status: _____

2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. Describe the nature of the emergency: _____

3. For retroactive Medicaid eligible recipients: The patient was not a Medicaid recipient at the time the hysterectomy was performed but was informed prior to the hysterectomy that the hysterectomy would make her permanently incapable of reproducing.

_____	_____	_____
Physician Name	Physician Signature	Date

Regulations require the physician who performs the hysterectomy (not secondary providers, such as an assisting surgeon or anesthesiologist) to complete the *Document for Hysterectomy/Acknowledgement Form (MDH 2990)*.

MARYLAND MEDICAL ASSISTANCE PROGRAM
DOCUMENT for HYSTERECTOMY/ACKNOWLEDGEMENT FORM AND INSTRUCTIONS
(MDH 2990)

INSTRUCTIONS

PART I

Recipient or Guardian/Representative Acknowledgement Statement
This section is required for all elective hysterectomies. **See Part III** for a patient who is already sterile or postmenopausal, when a hysterectomy was performed under a life-threatening emergency, or during a period of retroactive Medicaid eligibility.

- Enter the name of the Recipient.
- Enter the name of the Guardian/Representative if the recipient is unable to sign the Consent Form. If a representative is not used, indicate "N/A" in this field.
- Recipient must sign and enter the date of signature, unless a representative is being used to complete the form. **Date must be on or before the date of surgery.**
- Representative must sign and enter the date of signature if the recipient is unable to sign the form. **Date must be on or before the date of surgery.**
- Enter the name of the Witness of the consent form, signature, and date. **Date must be on or before the date of surgery.**
- Enter the name of the Interpreter, if indicated to obtain consent, signature and date. **Date must be on or before the date of surgery.**

PART II
Physician Certification Regarding Hysterectomy
This section is required for all medically indicated, non-emergent hysterectomies. **See Part III** for a recipient who is already sterile or postmenopausal, when a hysterectomy was performed under a life-threatening emergency, or during a period of retroactive Medicaid eligibility.

- Check and complete all of the blank spaces.
- Enter the name of the physician who will perform the hysterectomy.
- Enter the NPI # of the physician who will perform the hysterectomy.
- Physician must sign their name and enter the date of signature. **Date must be on or before the date of surgery.**

PART III
Waiver of Acknowledgement and Physician Certification
This section is required for a recipient who is already sterile or postmenopausal, when a hysterectomy was performed under a life-threatening emergency, or during a period of retroactive Medicaid eligibility.

- Check and complete the appropriate box(es).

- Enter the name of the physician who will perform the hysterectomy.
- Enter the NPI # of the physician who will perform the hysterectomy.
- Physician must sign their name and enter the date of signature. **Date must be on or before the date of surgery.**

The completed form, *Document for Hysterectomy/Acknowledgment Form (MDH 2990)* must be kept in the Recipient's medical record.

Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2018

CONSENT FOR STERILIZATION

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 _____ (*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 Temporary Assistance for Needy Families (TANF) 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 _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 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: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). 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 the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ 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's Signature*) _____ (*Date*)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of 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 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 consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) 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 appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: 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'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)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

Maryland
DEPARTMENT OF HEALTH

PREAUTHORIZATION REQUEST FORM
PHYSICIAN SERVICES

SECTION I- PATIENT INFORMATION

MEDICAID NUMBER (11 DIGIT)		TELEPHONE
NAME (LAST, FIRST, MI)		ADDRESS
DOB	SEX	

SECTION II- PROVIDER INFORMATION

PAY TO PROVIDER # (9 DIGIT)	**RENDERING** PROVIDER # (9 DIGIT)
NAME	NAME
ADDRESS	ADDRESS
TELEPHONE	TELEPHONE
PROVIDER SIGNATURE	
Contact information for person completing this form:	

NAME	EMAIL	PHONE

SECTION III- PREAUTHORIZATION INFORMATION

REQUEST DATE	DATES OF SERVICES: FROM THRU
DIAGNOSIS CODES: 1.	2. 3.

SECTION IV- PREAUTHORIZATION LINE ITEM INFORMATION

CODE	MOD 1	MOD 2	REQUESTED UNITS	DEPARTMENT USE ONLY

SECTION V- SPECIFIC PROGRAM PREAUTHORIZATION INFORMATION

PLEASE ATTACH CORRESPONDENCE WHICH INCLUDES BUT IS NOT LIMITED TO THE FOLLOWING:

A. COMPLETE NARRATIVE JUSTIFICATION FOR PROCEDURE(S)
B. BRIEF HISTORY AND PHYSICAL EXAMINATION
C. RESULT OF PERTINENT ANCILLARY STUDIES IF APPLICABLE
D. PERTINENT MEDICAL EVALUATIONS AND CONSULTATIONS IF APPLICABLE

PREAUTHORIZATION NUMBER (DEPARTMENT USE ONLY)

SUBMISSION INSTRUCTIONS:
Fax completed form and all required attachments to:
1-410-767-6034.