FORWARDHEALTH
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

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

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

INSTRUCTIONS
The Acknowledgement of Receipt of Hysterectomy Information form, F-1160, is to be completed by a physician before performing the surgery and attached to the 1500 Health Insurance Claim Form. **This form is mandatory; use an exact copy of this form.** ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form.

ForwardHealth reimbursement for a hysterectomy requires 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 member must give voluntary written consent on the federally required Sterilization Informed Consent form, F-1164.

Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth 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.

Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. This identification number must match the identification number on the claim.

Address — Member
Enter the member's address. Use the EVS to obtain the member's address.

Name — Physician
Enter the rendering provider's name.

National Provider Identifier
Enter the rendering provider's National Provider Identifier (NPI). This rendering provider NPI must match the rendering provider NPI indicated on the claim.

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

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

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

Interpreter — An interpreter must sign and date this element if the member 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 member 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.

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-1160 (10/08)

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

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Instructions: Print or type clearly. Before completing this form, refer to the Acknowledgement of Receipt of Hysterectomy Information Completion Instructions, F-1160A.

Name — Member	Member Identification Number
Address — Member	
Name — Physician	National Provider Identifier

It has been explained to ______________________________ (me) that the hysterectomy to be
(Name — Member)
performed on her (me) will render her (me) permanently incapable of reproducing.

SIGNATURES — Member, Representative, and Interpreter	
Member	Date Signed
Representative	Date Signed
Interpreter	Date Signed

F-1160