MVP Medicaid Managed Care
Prior Authorization Request Form for Sterilization and/or Hysterectomy

All providers rendering sterilizations and hysterectomies for members enrolled in MVP Medicaid Managed Care must have a consent or information form on file. This is specified in regulations Public Health regulation 42 CFR, Part 441, sub-part F, and New York 18 NYCRR §505.13.

Copies of the *New York State Sterilization Consent Form (DSS-3134)* and the *New York State Hysterectomy Information Form (DSS-3113)*, as well as this form, can be found at **www.mvphealthcare.com,** by selecting *Providers* and then *Forms*.

The applicable consent or information form should be completed and faxed or mailed with this form to the address shown below. <u>This is required for claim payment of the covered procedure.</u>

<u>Mail or Fax to:</u>
220 Alexander Street
Rochester, New York 14607
Fax: 585-327-5759
Questions? Call: 1-800-684-9286

Patient Name: _____

Date of Birth: _____

MVP ID#: _____

Requesting Physician/Mid Wife Name:_____

_____

NPI#: _____ _____

Address: _____

Office contact Name: _____

Phone number: _____

Fax number: _____

Requesting physician signature: _____

Referred to physician/Facility: _____

Address: _____

_____

Phone number: _____

Fax number: _____

Diagnosis: _____

ICD 9 code(s): _____

CPT Code(s): _____

Procedures/services Requested: _____

Services to be performed: □ Inpatient □ Outpatient □ Office

Attach copy of completed consent form to this form before faxing or mailing