

SEND TO:
 NM DEPT. OF HEALTH/PHD/FHB/FAMILY PLANNING PROGRAM
 2040 S. PACHECO, SANTA FE, NEW MEXICO 87505
 PHONE NUMBER: (505) 476-8882

FAMILY PLANNING PROGRAM STERILIZATION REQUEST FORM

CLIENT INFORMATION

1. Name (Last, First, Middle Initial)	2. Date of Birth	3. Date Consent Signed	4. Clinic Name
5. Type of Procedure Requested <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Post Partum Tubal Ligation <input type="checkbox"/> Vasectomy		6. Percent Pay (From current Federal Poverty Guidelines)	
7. Staff Name and Phone #	8. Priority Rating (Refer to Family Planning Protocol): <input type="checkbox"/> Priority A <input type="checkbox"/> Priority B Priority Justification: _____ _____		9. PHD Region

10. Pay Source

- Does client have private insurance? Yes No
 If yes, *STOP* and have client contact their insurance company.
- Does client have Medicaid (e.g. FP, Centennial Care MCOs)? Yes No
 If yes, *STOP* and refer to any provider accepting Medicaid.
- Is client eligible for FP Medicaid? Yes No
 (Eligibility for FP Medicaid: NM Resident, U.S. Citizen/approved immigrant status, income up to 235% Fed Poverty level and a Social Security Number).
 If yes, *STOP* and refer to Income Support Division.

11. I authorize the release of any medical information necessary to process this claim.
 I will be responsible for related cost not previously approved.

Autorizo la liberación de cualquier información de salud necesaria para procesar mi reclamación.
 Me haré responsable de cualquier costo relacionado que no haya sido aprobado previamente.

CLIENT SIGNATURE: _____

STATE FAMILY PLANNING OFFICE INFORMATION

12. Control Number	13. Consent Valid (30 days after signature)	14. Status of Request <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	
15. Consent Expiration (180 Days after signature)	16. Approval Date	17. Total Amount \$	18. Date put on pending list

PHYSICIAN INFORMATION (To be filled in by SURGEON)

AMOUNT APPROVED BY DEPT. OF HEALTH

19. Date Procedure/Service	Provided By	
_____ Tubal Surgery _____		\$ _____
_____ Facility _____		\$ _____
_____ Anesthesiology _____		\$ _____
_____ Vasectomy _____		\$ _____
		Approved By _____ PHD Staff

20. Accept assignment as per agreement with PHD Family Planning Program
 YES NO

DOH/PHD to remit payment for medical and/or other services indicated above to:

21. I certify that all services indicated were completed

Signature of Physician	Date	Please leave this area blank for State FP Office use I certify that this is true copy of the original and that payment for services has not been received
_____	_____	