

SECURE EMAIL TO:
 NM DEPT. OF HEALTH FAMILY PLANNING PROGRAM STERILIZATION TEAM
 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 Sterilization <input type="checkbox"/> Post Partum Tubal Sterilization <input type="checkbox"/> Vasectomy		6. Percent Pay (From current Federal Poverty Guidelines)	
7. Staff Name, Phone # and PHD Region	8. Priority Rating (Refer to Family Planning Protocol): <input type="checkbox"/> Priority A <input type="checkbox"/> Priority B Priority Justification: _____ _____		9. Client contact information (Phone # included)

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
 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. Co-pay is non-refundable.

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. El copago no es reembolsable.

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	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
Signature of Physician _____ Date _____	