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 ☐Tubal Sterilization ☐Post Partum Tubal Sterilization ☐Vasectomy		6. Percent Pay (From current Federal Poverty Guidelines)	
7. Staff Name, Phone # and PHD Region	8. Priority Rating (Refer to Family Planning Protocol): ☐ Priority A ☐ 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
  (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. 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 ☐ Approved ☐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
Signature of Physician Date	I certify that this is true copy of the original and that payment for services has not been received