NEVADA MEDICAID
INSTRUCTIONS FOR COMPLETING FORM HHS-687 - CONSENT FOR STERILIZATION

Nevada Medicaid providers must use the Federal Consent for Sterilization (form HHS-687), which is available on the U.S. Department of Health and Human Services website on the Grant Programs Key Resources for Title X Grantees webpage. Or use the following link to open and save the form: https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf

Medicaid payment is available for surgical procedures and/or contraceptive devices that result in permanent sterilization when all of the following conditions have been met:

- The recipient is at least 21 years old at the time consent is obtained.
- The recipient is neither mentally incompetent nor institutionalized.
- The recipient is not in labor (childbirth).
- The recipient is not under the influence of alcohol or other drugs.
- The recipient is not seeking or obtaining an abortion.
- The recipient has voluntarily given informed consent and signed the Sterilization Consent Form (HHS-687) (https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf).
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization.

Consent must be obtained at least 30 calendar days, but not more than 180 calendar days, prior to the date of sterilization, except in the cases of premature delivery or emergency abdominal surgery. For additional information, please refer to the Nevada Medicaid Sterilization and Abortion Policy Billing Instructions: https://www.medicaid.nv.gov/Downloads/provider/NV_Billing_Sterilization.pdf

INSTRUCTIONS TO COMPLETE FORM HHS-687

CONSENT TO STERILIZATION:

Doctor or Clinic (required)
The Physician or Clinic Name must be completed; this does not need to correspond with the physician or clinic on the claim.

Specify Type of Operation (required)
Indicate the name of the operation. Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes and abbreviations will be accepted.

Date (required)
The recipient must be 21 years old on the date the consent was given (month, day and year). The month, day and year must be clearly indicated.

Name of Recipient (required)
The recipient's name must be legible and must correspond to the recipient name on the claim.

Doctor or Clinic (required)
Must be completed and must correspond with the physician listed in the Physician's Statement.

Specify Type of Operation (required)
Indicate the name of the operation. HCPCS codes, CPT codes and abbreviations will be accepted.

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Signature and Date (required)
The recipient must sign and date the consent form. The date must be a minimum of 30 days and not more than (maximum) 180 days prior to the date of service on the claim. If it is less than 30 days, use of the alternative final paragraph under the Physician's Statement must be marked appropriately. An electronic signature is accepted.

Ethnicity and Race Designation (not required)

INTERPRETER'S STATEMENT:

The Interpreter's Statement is not required, but if any portion is completed, all parts must be completed.

Language, Interpreter's Signature, Date
The date of interpreter's signature must correspond to the date the recipient signed. An electronic signature is accepted.

STATEMENT OF PERSON OBTAINING CONSENT:

Name of Individual (required)
The recipient's name must correspond to the name on the claim.

Specify Type of Operation (required)
Indicate the name of the operation. HCPCS codes, CPT codes and abbreviations will be accepted.

Signature of Person Obtaining Consent, Date, Facility, Address (required)
Signature of the person obtaining consent and the date must be completed, but does not need to correspond with the recipient signature date. Facility name and address must be completed; this does not need to correspond with the physician or clinic on the claim. An electronic signature is accepted.

PHYSICIAN'S STATEMENT:

Name of Individual (required)
Must correspond to recipient name on the claim

Date of Sterilization (required)
Must correspond to the date of service on the claim.

Specify Type of Operation (required)
Indicate the name of the operation. HCPCS codes, CPT codes and abbreviations will be accepted.

Alternative Paragraph (required)
One of the two paragraphs must be crossed out:

A) If Paragraph 2 is crossed out, verify the claim date of service is at least 30 days from the date the recipient signed the consent.

B) If Paragraph 1 is crossed out, verify the date of service is less than 30 days but greater than 72 hours from date of recipient signature.
    a. If Paragraph 1 is crossed out, Paragraph 2 must be completed by checking the box for either “Premature delivery” or “Emergency abdominal surgery.”

Physician’s Signature (required)
Must be completed; this does not need to correspond with the physician or clinic on the claim. An electronic signature is accepted.

Physician’s Date (required)
Must be completed; is not required to correspond with the date of surgery.