|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CONTRACTOR NAME/LINE OF BUSINESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **NAME OF INDIVIDUAL COMPLETING FORM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **DATE OF SERVICE** | **MEMBER NAME** | **MEMBER ID #** | **DATE OF BIRTH** |  | **DATE OF CONFIRMATORY TESTING**  **(IF REQUIRED)** |  | **MEDICAL NECESSITY CONFIRMED AND SUPPORTING DOCUMENTATION ATTACHED** | |
| / / |  |  | / / |  | / / |  | Yes | No |
| / / |  |  | / / |  | / / |  | Yes | No |
| / / |  |  | / / |  | / / |  | Yes | No |
| / / |  |  | / / |  | / / |  | Yes | No |
| / / |  |  | / / |  | / / |  | Yes | No |
| / / |  |  | / / |  | / / |  | Yes | No |
| / / |  |  | / / |  | / / |  | Yes | No |
| Total number of sterilizations being reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |

All sterilizations for AHCCCS Members under 21 years of age must be reported by contractors as specified in contract, following an adjudicated sterilization claim or completed confirmatory testing (when such testing is required).  Refer to reporting instructions in AMPM Policy 420 for more detail related to the use of this form.