ORHP

VASECTOMY SERVICES RENDERED FORM

For use by Vasectomist to indicate which services were provided for a RHCare or CCare clinic-referred client. Please complete separate form for EACH service – one for the sterilization counsel and one for the vasectomy procedure. Information from this form will be used to bill for vasectomy services.

Provider Name: _____ Provider Phone: _____

Client Name: _____ Client DOB: _____

Date of Vasectomy Counsel (if applicable): _____

Date of Vasectomy Procedure (if applicable): _____

Check the boxes of services if performed:

COUNSELING PROVIDED *Only required if Sterilization Counsel performed*	**MEDICAL SERVICES** *Only required when Vasectomy performed*
☐ 01 – Contraceptive	☐ 20 – Vasectomy Procedure
☐ 03 – Sterilization [Required]	☐ 36 – Other Lab or Exam

Payment Amount Received (i.e. client fee, private insurance, Medicaid): _____

PROVIDER, BY SUBMITTAL OF THIS SERVICES RENDERED FORM, HEREBY DECLARES THE STATED SERVICES WERE PERFORMED.

Signature: _____ Date: _____