

SERVICES RENDERED FORM
Oregon Health Authority
Oregon Vasectomy Project

For use by Vasectomist to indicate which services were provided for a RH 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 <i>Only required if Sterilization Counsel performed</i>	MEDICAL SERVICES <i>Only required when Vasectomy performed</i>
<input type="checkbox"/> 01 – Contraceptive Options <input type="checkbox"/> 03 – Sterilization [Required]	<input type="checkbox"/> 02 – Blood Pressure <input type="checkbox"/> 20 – Sterilization Procedure <input type="checkbox"/> 42 – Male Genitalia Exam <input type="checkbox"/> 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: _____