

ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION**Section I: Patient Information** *(please type or print clearly)*

Patient's Name
Name of Patient's representative (if any)
Patient's Medicaid Number
Date of Hysterectomy

Section II: Patient acknowledgement of receipt of hysterectomy information

I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (sterile).

I have been informed, prior to the hysterectomy, that the hysterectomy will/would make me permanently incapable of reproducing (sterile).

Patient/Representative Signature	Date of Signature*
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**If the patient was not Medicaid eligible at the time of the hysterectomy, the date of signature may be after the date of the hysterectomy*

Section III: Provider acknowledgement of provision of hysterectomy information

Prior to the hysterectomy, I informed this patient *(and her authorized representative, if applicable)* both orally and in writing that the hysterectomy will make her permanently incapable of reproducing (sterile).

Name of person providing information	Signature of person providing information	Date of Signature*
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**If the patient was not Medicaid eligible at the time of the hysterectomy, the date of signature may be after the date of the hysterectomy*

Section IV: Physician Certification

The patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: *(check all that apply, please type or print clearly)*

- she was already sterile before the hysterectomy *(please briefly explain cause of the sterility; do not provide additional attachments):*
- the hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible *(please describe the nature of the emergency; do not provide additional attachments):*

Name of the physician who performed the hysterectomy <i>(please type or print clearly)</i>	Signature of the physician who performed the hysterectomy	Date of signature
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FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES.