Ohio Department of Medicaid

ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

Instructions: Complete Section I and either Section II or Section III.

Section I: Patient Information *(REQUIRED: Please type or print clearly)*

1	Patient's Name		
2	Name of Patient's Representative *(if any)*		
3	Patient's 12 Digit **Medicaid** Number	4	Date of Hysterectomy

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)

Patient acknowledgment 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).

Prior to the hysterectomy, I have been/was informed, both orally and in writing that the hysterectomy would make me permanently incapable of reproducing (sterile).

5	Patient/Representative Signature	6	Date of Signature

Provider acknowledgment 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 would make her permanently incapable of reproducing (sterile).

7	Name of Person Providing Information	8	Signature of Person Providing Information	9	Date of Signature

Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.

Prior to the hysterectomy, 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, do not provide additional attachments)*

10 ☐ She was already sterile before the hysterectomy *(please briefly explain cause of the sterility)*:

11 ☐ 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)*:

12	Name of the physician who performed the hysterectomy *(please type or print clearly)*		
13	Signature of the physician who performed the hysterectomy	14	Date of Signature

FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES

Distribution: One copy to patient, one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist.