SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ **MEDICAID #** _____
LAST FIRST MI

BIRTHDATE _____ **GRAVITY** _____ **PARITY** _____
MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____ _____
NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ **PLANNED SURGERY DATE** _____

TYPE OF HYSTERECTOMY PLANNED_____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

_____
_____
_____
_____
_____
_____
_____
_____

HCT ☐ **HGB** ☐ **CHECK ONE: PREMENOPAUSAL** ☐ **POSTMENOPAUSAL** ☐

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

_____
_____
_____

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

_____
_____
_____

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____ _____
LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ **TELEPHONE (_____)** _____

FAX (_____) _____

SIGNATURE _____ **DATE** _____
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12