

Ohio Department of Medicaid
ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

Name of patient <i>(as it appears on the claim)</i>	Name of physician who performed the hysterectomy
Patient's 12-digit Medicaid number	Date of hysterectomy
Name of patient's authorized representative <i>(if any)</i>	

Instruction: Complete either Section A or Section B.

<p>SECTION A: ACKNOWLEDGMENT THAT HYSTERECTOMY INFORMATION WAS PROVIDED PRIOR TO HYSTERECTOMY PROCEDURE(S)</p> <p style="text-align: center;">●————●</p> <p><i>Provider acknowledgment that hysterectomy information was given:</i></p> <p>Prior to the hysterectomy, I informed this patient (and the patient's authorized representative, if applicable), both orally and in writing, that the hysterectomy would make the patient permanently incapable of reproducing (<i>sterile</i>).</p> <p>Name of person providing information: _____</p> <p>Signature of person providing information: _____</p> <p>Date of signature: _____</p> <p style="text-align: center;">●————●</p> <p><i>Patient acknowledgment that hysterectomy information was received:</i></p> <p>I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is/was medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (<i>sterile</i>). Prior to the hysterectomy, I have been/was informed, both orally and in writing, that the hysterectomy would make me permanently incapable of reproducing (<i>sterile</i>).</p> <p>Signature of patient or authorized representative: _____</p> <p>Date of signature: _____</p>	<p>SECTION B: REASON WHY HYSTERECTOMY INFORMATION WAS NOT PROVIDED PRIOR TO HYSTERECTOMY PROCEDURE(S)</p> <p><i>(Check each item that applies. Provide a brief explanation. Do not include attachments.)</i></p> <p>Prior to the hysterectomy, this patient was not informed that hysterectomy makes an individual permanently incapable of reproducing (<i>sterile</i>). This information was not provided for the following reason(s):</p> <p><input type="checkbox"/> The patient was already sterile before the hysterectomy. Cause of sterility:</p> <p><input type="checkbox"/> The hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible. Nature of the emergency:</p>
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A completed copy of this form must be included with each claim for services.