Hysterectomy Acknowledgement Form

MISSISSIPPI DIVISION OF MEDICAID

Beneficiary Name:_____ **Medicaid ID #:** _____

Date of Hysterectomy Procedure: _____

Complete Part I if the beneficiary is not sterile and the hysterectomy procedure is not an emergency.
Complete Part II if the beneficiary is sterile, if the hysterectomy procedure is an emergency, or for retroactive eligibility.

PART I:

Beneficiary or Guardian/Legal Representative Acknowledgement Statement

I acknowledge that I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation. I received this oral and written explanation that the hysterectomy would make me sterile before the hysterectomy procedure.

_____ _____
Signature of Beneficiary or Guardian/Legal Representative Date of Signature

_____ _____
Signature of Person Securing Authorization for Procedure Date of Signature

Physician Certification Regarding Hysterectomy

I certify the hysterectomy procedure is medically necessary due to the diagnosis_____, diagnosis code_____, and is not performed solely for the purpose of sterilization. Prior to the hysterectomy procedure, the beneficiary and her guardian/legal representative, if any, were informed both orally and in writing that the beneficiary would be permanently incapable of reproducing as a result of this hysterectomy procedure.

_____ _____
Signature of Physician Date of Signature

PART II:

PHYSICIAN – Waiver of Acknowledgement and Physician Certification

The hysterectomy performed on the above named beneficiary was solely for medical indications and was not for the purpose of sterilization. Check the appropriate box(es) below.

☐ 1. The patient was sterile prior to the hysterectomy.
Cause of sterility_____

☐ 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible.
Describe the nature of the emergency:

_____

☐ 3. For retroactive Medicaid eligible beneficiaries: The patient was not a Medicaid beneficiary at the time the hysterectomy was performed but was informed prior to the hysterectomy procedure that the procedure would make her permanently incapable of reproducing.

_____ _____
Signature of Physician Date of Signature