Ohio Department of Medicaid

ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

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

Instruction: Complete either Section A or Section B.

SECTION A: ACKNOWLEDGMENT THAT HYSTERECTOMY INFORMATION WAS PROVIDED PRIOR TO HYSTERECTOMY PROCEDURE(S)

Provider acknowledgment that hysterectomy information was given:

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 *(sterile)*.

Name of person providing information:

_____

Signature of person providing information:

_____

Date of signature: _____

Patient acknowledgment that hysterectomy information was received:

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 (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).

Signature of patient or authorized representative:

_____

Date of signature: _____

SECTION B: REASON WHY HYSTERECTOMY INFORMATION WAS NOT PROVIDED PRIOR TO HYSTERECTOMY PROCEDURE(S)

(Check each item that applies. Provide a brief explanation. Do not include attachments.)

Prior to the hysterectomy, this patient was not informed that hysterectomy makes an individual permanently incapable of reproducing (sterile). This information was not provided for the following reason(s):

☐ The patient was already sterile before the hysterectomy.

Cause of sterility:

☐ The hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible.

Nature of the emergency:

A completed copy of this form must be included with each claim for services.

Distribution: One copy each to patient, facility, physician, and anesthesiologist