



**STATE OF FLORIDA
EXCEPTION TO HYSTERECTOMY
ACKNOWLEDGEMENT REQUIREMENT
State of Florida Physicians Certification Statement for
Exception to Hysterectomy Acknowledgement Requirement**

SECTION I

I _____, _____ certify that
(PRINT PHYSICIAN NAME) (PROVIDER NUMBER)
the condition(s) marked below existed at the time a hysterectomy was
performed for _____.
(PRINT RECIPIENT'S NAME) (MEDICAID I.D. NUMBER)

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_____ A. The recipient was already sterile at the time of the hysterectomy.

Specify cause of sterility:

 4

_____ Postmenopausal

_____ Congenital disorder: Specify _____

 5

_____ Previously surgically sterilized: Specify method _____

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_____ B. The recipient requires an emergency hysterectomy because of a life threatening emergency situation. (The emergency situation must render the recipient incapable of understanding or responding to the information pertaining to the acknowledgement agreement because of the emergency nature of her admission). Please describe the nature of the emergency below.

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SECTION II

Physician Statement of Certification

For the above reason(s), I am requesting an exception to the hysterectomy acknowledgement requirement for the hysterectomy services indicated on the attached claim for (CMS-1500 or UB 04).

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(Physician Signature)

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Fiscal Agent Screening
Supervisor

(Date)