



**STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGMENT FORM**

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

_____, _____, understand that the Florida
(PRINT PHYSICIAN'S NAME) (PROVIDER NO.)
Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

(ENTER DX AND EXPLAIN IF NECESSARY)

PHYSICIAN'S SIGNATURE DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

(PRINT: RECIPIENT'S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

PATIENT'S SIGNATURE OR MARK DATE

Patient's mark must be witnessed by her representative.

INTERPRETER'S SIGNATURE, WHEN NECESSARY DATE

DISTRIBUTION OF COPIES:

- ORIGINAL - Retain in patient's medical record at physician's office.
- 1 COPY - To patient.
- Other copies as required - See note below.

NOTE: A copy of this form shall be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.