

Acknowledgment/Certification Statement for a Hysterectomy

Section I or Section II of this form must be completed and attached to all paper claims for payment.

Section I. (Patient information)

Do **not** complete this section *if*:

- The patient was already sterile at the time of the hysterectomy
- The hysterectomy was performed because of a life threatening emergency and prior acknowledgment was not possible.

Patient's name: _____

Patient's address: _____

Colorado Medical Assistance Program State ID number: _____ Date of service: _____

I have asked for and received information about the hysterectomy from:

(name of doctor or clinic)

I understand that a hysterectomy is being performed for medical reasons. I acknowledge that prior to surgery I was advised that a hysterectomy is a procedure that will render me permanently incapable of bearing children.

Patient's or representative's signature

Date

Section II. (Physician information)

This section must be completed by the physician performing the hysterectomy if:

- The patient was already sterile at the time of the hysterectomy
- The hysterectomy was performed because of a life threatening emergency and prior acknowledgment was not possible.

Physician's name: _____ Colorado Medical Assistance Program provider number: _____

Patient's name: _____ Colorado Medical Assistance Program State ID number: _____

Please check and complete the paragraph that applies to this patient:

- I certify that the above named patient was already sterile at the time of the hysterectomy. The sterility was due to:

- I certify that the above named patient required a hysterectomy under a life-threatening, emergency situation. During the emergency, I determined that prior acknowledgment by the patient was not possible. A description of the nature of the emergency follows:

Physician's signature

Date