STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Hysterectomy Information

PART I - PHYSICIAN'S STATEMENT (To be completed by the physician's office)

_____ _____
Physician's Name (Print) Provider Identification Number

I understand the Florida Medicaid program will not reimburse for a hysterectomy service unless it is performed in accordance with the federal requirements as specified in Title 42, Code of Federal Regulations, Section 441, Subpart F. The hysterectomy to be performed is not solely for the purpose of rendering the below named recipient permanently incapable of reproducing, nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The non-elective hysterectomy is therefore being performed for the following medical reasons (include any applicable diagnosis):

_____

_____

_____

_____

_____ _____
Physician's Signature Date

PART II- RECIPIENT'S STATEMENT (To be completed by the Florida Medicaid recipient)

_____ _____
Recipient Name (Print) Florida Medicaid Identification Number

I was told verbally, and in writing, that I will not be able to have children after this surgery.

_____ _____
Recipient's Signature Date

_____ _____
Interpreter's Signature (If necessary) Date

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