

Hysterectomy Consent Form

Complete Section 1 if the patient is not sterile and the hysterectomy procedure is **not** an emergency (side 1 of this form).

Complete Section 2 if the patient is sterile, if the hysterectomy **is** an emergency, or for retroactive eligibility (side 2 of this form).

Attach this completed form to the prior authorization request and the claim for reimbursement.

You do not need to submit a sterilization consent form.

Patient name (print first and last name)

Patient date of birth (mm/dd/yy)

Apple Health Client ID (ProviderOne) number

Section 1. Acknowledgement statement by patient or guardian/legal representative

PATIENT: I understand that a hysterectomy (surgical removal of my uterus) is medically necessary and I have agreed to this operation. I acknowledge that I have been advised orally and in writing that the hysterectomy will cause me to be permanently incapable of reproducing (become sterile).

Signature of patient or authorized representative

Date of signature

Interpreter used? Yes No

INTERPRETER: To be completed by the interpreter when an interpreter is used.

I am a certified/authorized interpreter in _____ (language).
I certify that I've interpreted the verbal information and read the acknowledgement statement (above) to this patient in the language I listed.

Signature of interpreter

Date of signature

Interpreter's full name (please print)

Certificate number or interpreter's ID

PHYSICIAN CERTIFICATION: I certify the hysterectomy is medically necessary and is not performed solely for the purpose of sterilization. Prior to the hysterectomy, the patient and her authorized representative (if any), were informed both orally and in writing that the patient would be permanently incapable of reproducing (become sterile) as a result of the procedure.

Expected date of hysterectomy procedure

Actual date of hysterectomy procedure (if different)

Diagnosis description

Diagnosis code

Physician name (print first and last name)

Signature of physician

Date of signature

Section 2. Physician certification and waiver of acknowledgement

Date of hysterectomy procedure: _____

The hysterectomy performed on this patient was solely done for medical reasons and was not done for the purpose of sterilization. Check all boxes below that apply.

The patient was not informed that a hysterectomy would make her permanently incapable of reproducing because she was sterile before the hysterectomy.

Cause of sterility: _____

The patient was not informed that a hysterectomy would make her permanently incapable of reproducing because the hysterectomy was performed in a life-threatening emergency and prior acknowledgement was not possible.

Describe the nature of the emergency: _____

Check this box only for a patient eligible for retroactive Apple Health coverage: The patient was not an Apple Health client at the time the hysterectomy was performed, but I informed her before the hysterectomy that the procedure would make her permanently incapable of reproducing. (Attach a copy of the surgical consent and the supporting chart note.)

Physician name (print first and last name)

Signature of physician

Date of signature