



ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART I - (MUST BE COMPLETED)

Recipient Name
Recipient Identification No.
Physician Name Provider No.

PART II - ACKNOWLEDGEMENT

It has been explained to and the patient's representative, if any, orally and in writing that the hysterectomy to be performed on the patient will render the patient permanently incapable of reproducing.

Recipient or Representative Signature Date

(If required, Interpreter Signature) Date

PART III - PHYSICIAN STATEMENT

In my professional judgment, the hysterectomy is not being performed solely to accomplish sterilization; it is being performed for other medically necessary reasons.

Physician Signature Date

PART IV - EXCEPTION REQUEST

- Exception 1 - I certify that the above named individual was already sterile at the time of the hysterectomy. The cause of the sterility was
Exception 2 - I certify that the hysterectomy performed on the above named individual was performed under a life threatening emergency situation, i.e., in which I determined prior acknowledgment of receipt of hysterectomy information was not possible. I have attached a copy of the hospital operative record or other written explanation as to the nature of the emergency.
Exception 3 - The above named individual had a hysterectomy performed during a period of retroactive Medicaid eligibility. Date of Surgery

I certify that the above named individual was informed prior to the operation that the hysterectomy would render the patient permanently incapable of reproducing; or that Exception 1 () or Exception 2 (), as certified above, made such explanation unnecessary or impossible.

Physician Signature Date

Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form approved by the Forms Management Center.