

**STATE OF FLORIDA  
EXCEPTION TO HYSTERECTOMY  
ACKNOWLEDGEMENT REQUIREMENT**

**Physicians Certification Statement**

**SECTION I – SERVICE INFORMATION**

\_\_\_\_\_  
Recipient Name (Print) Florida Medicaid Identification Number

Complete reason for exception:

\_\_\_\_\_ **A.** The recipient was already sterile at the time of the hysterectomy. Specify cause of sterility:

\_\_\_\_\_ Postmenopausal

\_\_\_\_\_ Congenital disorder. Specify: \_\_\_\_\_

\_\_\_\_\_ Previously surgically sterilized. Specify method: \_\_\_\_\_

\_\_\_\_\_ **B.** The recipient requires an emergency hysterectomy because of a life threatening emergency situation. (The emergency situation must render the recipient incapable of understanding or responding to the information pertaining to the acknowledgement agreement because of the emergency nature of her admission). Please describe the nature of the emergency below.

**SECTION II – PHYSICIAN'S CERTIFICATION**

\_\_\_\_\_  
Physician's Name (Print) Provider Identification Number

I certify that the condition(s) indicated existed at the time a hysterectomy was performed for the above named recipient. For the above reason(s), I am requesting an exception to the hysterectomy acknowledgement requirement for the hysterectomy services indicated on the attached claim for (CMS-1500 or UB 04).

\_\_\_\_\_  
Physician's Signature Date

For Official Use Only

\_\_\_\_\_  
Fiscal Agent Screening Supervisor