## 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 performed in accordance with the federal requirer Regulations, Section 441, Subpart F. The hysterectom rendering the below named recipient permanently incomedical purposes which by themselves do not mandatis therefore being performed for the following medica	ments as specified in Title 42, Code of Federa by to be performed is not solely for the purpose of capable of reproducing, nor is the hysterectomy for the a hysterectomy. The non-elective hysterectomy
Physician's Signature  PART II- RECIPIENT'S STATEMENT (To be completed by	Date y the Florida Medicaid recipient)
Recipient Name (Print)	Florida Medicaid Identification Number
I was told verbally, and in writing, that I will not be abl	e 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.