



Acknowledgement/Certification Statement for a Hysterectomy

Complete Section I **or** Section II and attach to claim for processing.

Section I. Member Information

Do not complete this section if:

- The member was already sterile at the time of the hysterectomy.
- The hysterectomy was performed because of a life-threatening emergency and prior acknowledgment by the member was not possible.

1. Member Health First Colorado ID: _____

2. Member Name: _____

3. Member Address: _____

Date of service: _____

I have asked for and received information about the hysterectomy from.

Name of Doctor or Clinic

I understand that a hysterectomy is being performed for medical reasons. I acknowledge that prior to surgery I was advised that a hysterectomy is a procedure that will render me permanently incapable of bearing children.

Member's or Representative's Signature

Date





Section II. Physician Information

The physician performing the hysterectomy completes this section if:

- The member was already sterile at the time of the hysterectomy.
- The hysterectomy was performed because of a life-threatening emergency and prior acknowledgment by the member was not possible.

Physician Name

Provider Health First Colorado ID

Member Name

Member Health First Colorado ID

Check and complete the paragraph that applies to the member:

I certify that the above-named member was already sterile at the time of the hysterectomy. The sterility was due to: _____

I certify that the above-named member required a hysterectomy under a life-threatening emergency situation. During the emergency, I determined that prior acknowledgment by the patient was not possible. A description of the nature of the emergency follows: _____

Physician Signature

Date

Revised January 2019

