Acknowledgment/Certification Statement for a Hysterectomy

Section I or Section II of this form must be completed and attached to all claims for payment.

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.**

Member's name: _____

Member's address: _____

Health First Colorado State ID number: _____ 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)

This section must be completed by the physician performing the hysterectomy 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's name: _____ Health First Colorado provider number: _____

Member's name: _____ Health First Colorado State ID number: _____

Please check and complete the paragraph that applies to this 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's signature Date