MARYLAND MEDICAL ASSISTANCE PROGRAM

DOCUMENT FOR HYSTERECTOMY

COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR HYSTERECTOMIES.

Please Print or Type

PATIENT'S NAME

PATIENT'S ADDRESS

PATIENT'S MEDICAL ASSISTANCE NUMBER

PHYSICIAN COMPLETING FORM

PHYSICIAN'S MEDICAL ASSISTANCE NUMBER

PLACE OF SERVICE

DATE OF SERVICE

SECTION I - To be signed by physician and patient or patient's representative when patient has been informed of the service.

A. I have performed a hysterectomy on _____ (NAME OF PATIENT) . I hereby certify that the following conditions do not apply to this hysterectomy.

1. It was performed solely for the purpose of rendering the individual permanently incapable of reproducing; or
2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

I have informed the patient and her representative, if any, orally and in writing, that the hysterectomy will make the patient permanently incapable of reproducing.

DATE

SIGNATURE OF PHYSICIAN

B. Receipt of Hysterectomy Information

I, _____ (NAME OF PATIENT) have been informed by

_____ (NAME OF PHYSICIAN) , that the hysterectomy to be performed will render me permanently incapable of reproducing.

DATE

SIGNATURE OF PATIENT OR REPRESENTATIVE

SECTION II - To be signed by physician. No patient signature is needed because the individual:

A. Was already sterile before the hysterectomy due to _____ (CAUSE OF STERILITY): or

B. Required a hysterectomy performed under a life-threatening emergency situation in which prior acknowledgement was not possible. (Describe the nature of the emergency.)

_____

_____

_____

DATE

SIGNATURE OF PHYSICIAN

DHMH 2990 (Rev. 10/82)