

**Guidelines for completing the
ODJFS ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION**
JFS 03199 (Rev 4/2011)

Section I: Patient Information – *always complete*

1. Patient's first and last name
2. Name of patient's representative (if any)
3. Patient's Medicaid number (this is the MMIS12-digit number listed on CareSource ID card)
4. Date of hysterectomy

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s) – *complete when Section III is NOT completed*

5. Patient or representative signature acknowledging that they were informed both orally and in writing, prior to surgery
6. Date of signature
7. Name of physician representative providing procedural outcomes information (to the patient)
8. Signature of person providing information
9. Date of signature

Section III: Physician Certification of reason for not providing hysterectomy information prior to the hysterectomy procedure – *complete **only** if the member was sterile prior to surgery or was in a life-threatening emergency situation. If Section III is completed then Section II does not need to be completed.*

10. Physician indicates that the patient was already sterile before surgery
 - If this box is checked, briefly explain cause of the sterility (no attachments).
11. Physician indicates that surgery was performed under a life-threatening emergency situation
 - If this box is checked, briefly describe the nature of the emergency (no attachments).
12. Name of physician who performed the surgery (please type or print clearly)
13. Signature of physician who performed the surgery
 - This must be a signature and NOT a stamped signature.
14. Date of signature

The form must be accurately completed before CareSource can consider the claim for payment. Page ____ (#) is a blank ODJFS Acknowledgement of Hysterectomy Information Form that can be reproduced and used. This form can also be accessed on our website at www.caresource.com.