STATE OF FLORIDA
EXCEPTION TO HYSTERECTOMY
ACKNOWLEDGEMENT REQUIREMENT

Physicians Certification Statement

SECTION I – SERVICE INFORMATION

_____ _____
Recipient Name (Print) Florida Medicaid Identification Number

Complete reason for exception:

_____ **A**. The recipient was already sterile at the time of the hysterectomy. Specify cause of sterility:

_____ Postmenopausal

_____ Congenital disorder. Specify:_____

_____

_____ Previously surgically sterilized. Specify method:_____

_____

_____ **B.** The recipient requires an emergency hysterectomy because of a life threatening emergency situation. (The emergency situation must render the recipient incapable of understanding or responding to the information pertaining to the acknowledgement agreement because of the emergency nature of her admission). Please describe the nature of the emergency below.

SECTION II – PHYSICIAN'S CERTIFICATION

_____ _____
Physician's Name (Print) Provider Identification Number

I certify that the condition(s) indicated existed at the time a hysterectomy was performed for the above named recipient. For the above reason(s), I am requesting an exception to the hysterectomy acknowledgement requirement for the hysterectomy services indicated on the attached claim for (CMS-1500 or UB 04).

_____ _____
Physician's Signature Date

For Official Use Only

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Fiscal Agent Screening Supervisor