Acknowledgement of Receipt of Hysterectomy Information Form

_____ _____

Recipient's Name and Address ***WI Medicaid ID Number***

_____ _____

Physician's Name ***WI Medicaid Provider No.***

It has been explained to _____ that the hysterectomy to be performed on me (her) will render me (her) permanently incapable of reproducing.

Recipient's Signature _____

Representative's Signature _____

Interpreter's Signature _____

Date _____

The hysterectomy to be performed is not solely for the purpose of rendering the above-named recipient permanently incapable of reproduction, nor for medical purposes, which by themselves do not mandate a hysterectomy (such as fibroids, fallen uterus, and retroverted uterus).

Physician's Signature _____

Date _____

Completion Instructions –

Acknowledgement of Receipt of Hysterectomy Information Form

Recipient's Name and Address. Enter the recipient's name and address. The name in this element must match the name on the claim.

Recipient's Wisconsin Medicaid Identification Number. Enter the recipient's 10-digit identification number from the recipient's identification card. This identification number must match the identification number on the claim.

Physician's Name. Enter the performing provider's name.

Wisconsin Medicaid Provider Number. Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

Recipient's Name. Enter the recipient's name. The name must match the recipient's name entered at the top of the form

Recipient's Signature. The recipient must sign the form in this element.

Representative's Signature. If a representative was require for the recipient, the representative must sign the form in this element.

Interpreter's Signature. If the recipient does not understand that language used on the form, an interpreter must be use. The interpreter must sign the form in this element.

Date. Enter the date in this element. This date must be before the date of service on the claim.

Physician's Signature and Date. The provider must sign and date this element. This date must be before the date of service on the claim.