Hysterectomy consent form

Washington State Health Care Authority

Complete sections 2 and 3 only if the patient is not sterile and the hysterectomy procedure is not an emergency.
Complete Section 4 if the patient is sterile, if the hysterectomy is an emergency, or for retroactive eligibility.
To sign this request, do **not** use the "Fill & Sign" function; instead, simply click in the appropriate signature field to add your signature (if filling out digitally).

Attach this completed form to the prior authorization request and the claim for reimbursement. You do not need to submit a sterilization consent form.

1 Patient information

Patient name (print first and last name)

Patient date of birth (mm/dd/yyyy)

Apple Health Client ID (ProviderOne) number OR Apple Health MCO Member ID

2 Acknowledgement

Patient

I understand that a hysterectomy (surgical removal of my uterus) is medically necessary and I have agreed to this operation. I acknowledge that I have been advised orally and in writing that the hysterectomy will cause me to be permanently incapable of reproducing (become sterile).

Signature of patient or authorized representative

Date of signature (mm/dd/yyyy)

Interpreter used? ☐ Yes ☐ No

Interpreter

To be completed by the interpreter when an interpreter is used

I have translated the information and advice presented verbally to the client by the physician. I have also read the client the consent form in _____ (language) and explained the form's contents to the client.

Signature of Interpreter

Date of signature (mm/dd/yyyy)

Interpreter's full name (please print)

3 Physician certification

I certify the hysterectomy is medically necessary and is not performed solely for the purpose of sterilization. Prior to the hysterectomy, the patient and the patient's authorized representative (if any), were informed both orally and in writing that the patient would be permanently incapable of reproducing (become sterile) as a result of the procedure.

Expected date of hysterectomy procedure (mm/dd/yyyy)

Actual date of hysterectomy procedure (if different)

Diagnosis description

Diagnosis code

Physician name (print first and last name)

Signature of physician

Date of signature (mm/dd/yyyy)

4 Physician certification and waiver of acknowledgement

_____

Date of hysterectomy procedure (mm/dd/yyyy)

The hysterectomy performed on this patient was solely done for medical reasons and was not done for the purpose of sterilization. Check all boxes below that apply.

☐ The patient was not informed that a hysterectomy would result in the permanent inability to reproduce because the patient was sterile before the hysterectomy.

Cause of sterility

☐ The patient was not informed that a hysterectomy would result in the permanent inability to reproduce because the hysterectomy was performed in a life-threatening emergency and prior acknowledgement was not possible.

Desribe the nature of the emergency:

☐ Check this box only for a patient eligible for retroactive Apple Health coverage: The patient was not an Apple Health client at the time the hysterectomy was performed, but I informed the patient before the hysterectomy that the procedure would result in the permanent inability to reproduce. (Attach a copy of the surgical consent and the supporting chart note.)

_____

Physician name (print first and last name)

_____

Signature of physician

Date of signature (mm/dd/yyyy)