BHSF Form 96-A
Revised 05/06

**Medicaid Program**
**Acknowledgment of Receipt of Hysterectomy Information**

Recipient Name: _____
MEDS Person No.: _____
Physician Name: _____
Provider No.: _____

Payment by Louisiana's **Medicaid Program cannot** be authorized for **any** hysterectomy performed **solely** for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy **would not** be performed except for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized **only** if:
(1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; **and**,
(2) the individual and her representative* if any, have signed a written acknowledgment of receipt of that information. The written acknowledgment must be signed and dated prior to the operation and **must** be attached to the claim form when it is submitted for payment.

* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgment, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

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I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render a woman permanently incapable of bearing children.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Representative, if any Date