Hysterectomy Necessity Form

To be completed by the individual receiving the hysterectomy or her representative, if any:

_____ (Please print name and relation to patient.)

Please select one of the following choices and place your initials on the line next to the statement that best describes your situation.

___Prior to surgery, I received, orally and in writing, information stating that the hysterectomy would render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

___I am already sterile and incapable of bearing children. My physician and I have orally discussed my illness, and he or she has given me written information on my illness that has led to the discussion for this surgery. The illness/disease/symptoms that I have is/are called:

_____.

_____ _____
(Signature of Patient or Representative) (Date mm/dd/yr)

_____ _____
(Signature of Physician) (Date mm/dd/yr)

This form must be completed in its entirety.
Incomplete information may result in the claim being denied.

Please fax form to 1-800-964-3627
Attn: Medical Director

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