

**SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY**

THIS COMPLETED FORM AND A SIGNED "ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ MEDICAID # _____
 LAST FIRST MI

BIRTHDATE _____ GRAVITY _____ PARITY _____
 MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____
 NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ PLANNED SURGERY DATE _____

TYPE OF HYSTERECTOMY PLANNED _____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

HCT ___ HGB ___ CHECK ONE: PREMENOPAUSAL ___ POSTMENOPAUSAL ___

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____
 LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ TELEPHONE (____) _____

FAX (____) _____

SIGNATURE _____ DATE _____

ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.