

**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.