MARYLAND MEDICAL ASSISTANCE PROGRAM
DOCUMENT for HYSTERECTOMY/ACKNOWLEDGEMENT FORM AND INSTRUCTIONS
(MDH 2990)
See the end of this form for instructions on completing and submitting the form.

Recipient's Name: _____ Medicaid ID #: _____

Date of Hysterectomy Procedure: _____

Complete **Part I and II** if the recipient is not sterile, is premenopausal, and the hysterectomy is not an emergency procedure.

Complete **Part III** if the recipient is sterile or postmenopausal, if the hysterectomy is an emergency procedure, or for retroactive eligibility.

PART I

Recipient or Guardian/Representative Acknowledgement Statement

I acknowledge that I have been advised orally and in writing, prior to the surgery, that a hysterectomy will render me permanently incapable of becoming pregnant and having children and that I have agreed to this surgery. The indication for the hysterectomy, along with the risks and benefits associated with the surgery, has been explained to me and all my questions have been answered prior to the surgery.

_____	_____	_____
Recipient or Guardian/Representative Name	Recipient or Guardian/Representative Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date
_____	_____	_____
Interpreter Name	Interpreter Signature	Date

PART II

Physician Certification Regarding Hysterectomy

I certify the hysterectomy is medically necessary due to the diagnosis _____, ICD-10 diagnosis code _____, and is not performed solely for the purpose of sterilization. Prior to the hysterectomy, the recipient and her authorized representative, if any, were informed orally and in writing that the recipient would be permanently incapable of reproducing as a result of this hysterectomy.

_____	_____	_____	_____
Physician Name	Physician Signature	Physician NPI #	Date

PART III

Waiver of Acknowledgement and Physician Certification

The hysterectomy performed on the above recipient was solely for medical indications and was not for the purpose of sterilization. Check the appropriate box(es) below.

1. The recipient was sterile or postmenopausal at the time of the hysterectomy. Please document the diagnosis of sterility or postmenopausal status: _____

2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. Describe the nature of the emergency: _____

3. For retroactive Medicaid eligible recipients: The patient was not a Medicaid recipient at the time the hysterectomy was performed but was informed prior to the hysterectomy that the hysterectomy would make her permanently incapable of reproducing: _____

_____	_____	_____
Physician Name	Physician Signature	Date

Regulations require the physician who performs the hysterectomy (not secondary providers, such as an assisting surgeon or anesthesiologist) to complete the *Document for Hysterectomy/Acknowledgement Form (MDH 2990)*.

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INSTRUCTIONS

PART I

Recipient or Guardian/Representative Acknowledgement Statement
This section is required for all elective hysterectomies. **See Part III** for a patient who is already sterile or postmenopausal, when a hysterectomy was performed under a life-threatening emergency, or during a period of retroactive Medicaid eligibility.

- Enter the name of the Recipient.
- Enter the name of the Guardian/Representative if the recipient is unable to sign the Consent Form. If a representative is not used, indicate "N/A" in this field.
- Recipient must sign and enter the date of signature, unless a representative is being used to complete the form. **Date must be on or before the date of surgery.**
- Representative must sign and enter the date of signature if the recipient is unable to sign the form. **Date must be on or before the date of surgery.**
- Enter the name of the Witness of the consent form, signature, and date. **Date must be on or before the date of surgery.**
- Enter the name of the Interpreter, if indicated to obtain consent, signature and date. **Date must be on or before the date of surgery.**

PART II
Physician Certification Regarding Hysterectomy
This section is required for all medically indicated, non-emergent hysterectomies. **See Part III** for a recipient who is already sterile or postmenopausal, when a hysterectomy was performed under a life-threatening emergency, or during a period of retroactive Medicaid eligibility.

- Check and complete all of the blank spaces.
- Enter the name of the physician who will perform the hysterectomy.
- Enter the NPI # of the physician who will perform the hysterectomy.
- Physician must sign their name and enter the date of signature. **Date must be on or before the date of surgery.**

PART III
Waiver of Acknowledgement and Physician Certification
This section is required for a recipient who is already sterile or postmenopausal, when a hysterectomy was performed under a life-threatening emergency, or during a period of retroactive Medicaid eligibility.

- Check and complete the appropriate box(es).
- Enter the name of the physician who will perform the hysterectomy.
- Enter the NPI # of the physician who will perform the hysterectomy.
- Physician must sign their name and enter the date of signature. **Date must be on or before the date of surgery.**

The completed form, *Document for Hysterectomy/Acknowledgment Form (MDH 2990)* must be kept in the Recipient's medical record.