

**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.