South Carolina State Surgical Justification Form

COMPLETE THIS FORM AND RETURN IT, ALONG WITH A SIGNED "CONSENT FOR STERILIZATION" FORM, AT LEAST 30 DAYS BEFORE THE SCHEDULED SURGERY.

Patient name _____ Medicaid# _____
Last First MI

Birthday _____ Gravity _____ Parity _____
MM/DD/YY

Procedure code _____ Diagnosis code _____

Hospital name _____ NPI (if available) _____

Planned admission date _____ Planned sugery date _____

Type of hysterectomy planned _____

Gynecological history/physical exam relating to principal diagnosis:

_____

_____

_____

Hematocrit (HCT) _____ hemoglobin (HGB) _____ Check one: ❑ Premenopausal ❑ Postmenopausal

Conservative treatment/medication with dates:

_____

_____

_____

Prior gynecological 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 _____ NPI _____
Last First MI

Address _____

Contact person _____ Telephone _____ Fax _____

Attending physician signature _____ Date _____

Approvals are valid for 180 days from date of issue.

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