A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be reversed, and it will permanently prevent you from having children. A hysterectomy should only be performed when there is a disease of the woman's uterus or some other problem that can only be treated by removing the uterus. It is a serious operation and there are discomforts and a chance of serious health problems.

AHCCCS does not cover hysterectomy procedures when:

1. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing.

2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

My signature acknowledges that I have been informed and understand that a hysterectomy will permanently render me incapable of reproducing and that I have read and understand the above information**.**

_____
MEMBER'S NAME

_____ _____
MEMBER'S SIGNATURE *DATE*

_____ _____
MEMBER'S REPRESENTATIVE (WHEN APPLICABLE) *DATE*

BY SIGNING BELOW, I HEREBY CONSENT OF MY OWN FREE WILL TO UNDERGO A HYSTERECTOMY.

_____
MEMBER'S NAME

_____ _____
MEMBER'S SIGNATURE *DATE*

_____ _____
MEMBER'S REPRESENTATIVE (WHEN APPLICABLE) *DATE*

_____ _____
MEMBER'S AHCCCS IDENTIFICATION NUMBER *MEMBER'S SOCIAL SECURITY NUMBER*

Effective Dates: 07/01/17, 03/01/19, 04/01/22, 09/27/24, 07/01/25, 10/01/25, 07/16/26
Approval Dates: 03/01/98, 01/01/17, 05/03/18, 12/20/18, 01/13/22, 07/10/24, 03/25/25, 09/25/25, 07/05/26

In accordance with Federal Regulation 42 CFR 441.255, the signature and date below are required in order for reimbursement to be made.

PRINTED NAME OF PERSON WHO OBTAINED THE MEMBER'S CONSENT TO THE HYSTERECTOMY

TITLE OF PERSON WHO OBTAINED THE MEMBER'S CONSENT TO THE HYSTERECTOMY

SIGNATURE OF PERSON WHO OBTAINED THE MEMBER'S CONSENT TO THE HYSTERECTOMY

DATE

Effective Dates: 07/01/17, 03/01/19, 04/01/22, 09/27/24, 07/01/25, 10/01/25, 07/16/26
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