Aetna Better Health® of Oklahoma acknowledgment of receipt of hysterectomy information

This form is provided to meet the 42 CFR § 441.255 (c) Sterilization by hysterectomy and OAC: 317:30-5-19 Hysterectomies

Member name: _____

Address: _____

_____

Telephone number: _____

OHCA/SoonerSelect number: _____

Physician: _____

Address: _____

Prior to surgery, I have been informed, both orally and in writing, that as a result of the hysterectomy, which is to be performed by the doctor named above, I will be permanently incapable of reproduction.

_____
Member signature

_____
Date

4012963-01-01 (09/24)

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