

Cervical Cancer Screening Exclusion Form

Member Name: _____

Member ID#: _____

Date of Birth: _____

This member has had a total hysterectomy resulting in no residual cervix.

Date of total or radical abdominal hysterectomy with no residual cervix: _____

Diagnosis of Cervical Agenesis Date: _____

Documentation of a hysterectomy alone does not meet criteria for exclusion because it does not indicate that the cervix has been removed.

Medical record documentation must be attached to exclude the member.

Provider Signature: _____ Date: _____

Please fax the completed form to 312-508-7213.

Thank you for your cooperation in this important matter. Please call the MeridianHealth Quality Improvement department at **312-705-2900** if you have any questions.