meridianhealth
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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: _____

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

Please attach applicable medical record documentation.

Provider Signature: _____ Date: _____

Please fax the completed form to 313-202-0006.

Thank you for your cooperation in this important matter. Please call the MeridianHealth Quality Improvement department at 313-324-3700 if you have any questions.