ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: _____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____, certify that it was necessary to terminate the pregnancy of _____ for the following reason:

( ) A. Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: _____

( ) B. The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

( ) C. The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____
Physician's Signature Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____, certify that my pregnancy was the result of an act of rape of incest.

_____ _____
Patient's Signature Date

Both the completed Abortion Statement and appropriate medial records must be submitted with the claim. Form.

INSTRUCTIONS FOR COMPLETING THE ABORTION STATEMENT FORM

1. Patient's Name: The name of the patient can be typed or handwritten.

2. Patient's Medicaid ID #: The patient's Medicaid identification number can be typed or handwritten.

3. Patient Address: Patient's complete address. This can be typed or handwritten.

4. Name of Physician: The physician who performed the abortion procedure. This can be typed or handwritten.

5. Patient's Name: This can be typed or handwritten.

6. Reason: Check the box that indicates the necessity to terminate the pregnancy.

7. Name of Condition: The diagnosis or name of medical condition which makes abortion necessary.

8. Physician Signature: The physician must sign his/her name and date in his/her own handwriting.

9. Patient's Certification Statement: Complete this section only in cases of rape or incest.

10. Patient's Name: This can be typed or handwritten.

11. Patient's Signature: Patient must sign his/her name and date in his/her own handwriting.