

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 or 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.