

Invoice #:

Provider #:

Certification for Payable Abortion

*This form must be completed and kept in the member’s medical record. Please print.*

**Name of Patient**

Address of Patient

Date of Abortion Procedure

Name and City of Facility in Which Abortion Procedure Was Performed

*Check the appropriate box below to indicate which of the following four circumstances is applicable and complete that section of the form only.*

(1)  Life of the Pregnant Individual Would Be Endangered

I, (Print name of attending practitioner) , certify that on the basis of my professional judgment, the life of the above-named patient would be endangered if their pregnancy were carried to term.

(signature of attending practitioner) (date)

(2)  Severe and Long-Lasting Damage to Pregnant Individual’s Physical Health

*Complete both A and B below. Certification by two practitioners is required.*

**A.** I, (Print name of attending practitioner) , certify that on the basis of my professional judgment, severe and long-lasting physical damage to the above-named patient would result if their pregnancy were carried to term.

(signature of attending practitioner) (date)

**B.** I, (Print name of consulting practitioner) , certify that on the basis of my professional judgment, severe and long-lasting physical damage to the above-named patient would result if their pregnancy were carried to term. I also certify that I am not an "interested practitioner."\*

(signature of consulting practitioner) (date)

(3)  Victim of Rape or Incest

*Complete either A or B below.*

A. I, (Print name of agency authority) , of the, (Print name of law enforcement or public health agency)  
received a signed report from (Print name of person reporting incident)   
of (address)   
stating that the above-named patient was the victim of an incident of rape (or incest) that occurred on (date of incident) . Тhe report was made on (date of report) , which was within 60 days of the date on which the incident occurred.

(signature of law enforcement or public health agency authority) (date)

B.  Certification from a law enforcement or public health agency containing the above information is attached on a separate sheet.

(4)  Other Medically Necessary Abortion

I, (Print name of attending practitioner) , certify that on the basis of my medical judgment, for reasons other than those described in (1), (2), or (3) above, the abortion performed for the above-named patient was necessary in light of all factors affecting their health.

(signature of attending practitioner) (date)

\*Note:An "interested practitioner" is one: (a) whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or (b) who is the spouse of, or another relative who lives with, a practitioner whose income is directly or indirectly affected by the fee paid for the performance of the abortion.