



Certification for Payable Abortion

Invoice #:	_____
Provider #:	_____

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, _____, certify that on the basis of my professional
(Print name of attending practitioner)
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, _____, certify that on the basis of my professional
(Print name of attending practitioner)
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, _____, certify that on the basis of my professional
(Print name of consulting practitioner)
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, _____, of the, _____
(Print name of agency authority) (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 _____. The report was made on _____, which
(date of incident) (date of report)
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, _____, certify that on the basis of my medical
(Print name of attending practitioner)
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.