

Certification Statement/Case Summary

Abortion Services (Sexual Assault or Incest)

This form must be completed and submitted with abortion claims for processing.

Section I. Patient Information (to be completed by the client)

1. Client Medicaid ID: _____
2. Client Name: _____
3. Client Address: _____
4. Age of Client: _____ 5. Gestational Age of Fetus: _____

Please check the box that most closely describes your situation:

- Pregnancy resulting from sexual assault (rape)
- Pregnancy resulting from incest

Section II. Practitioner Information (to be completed by the practitioner)

I was advised by the patient that:

- This pregnancy is a result of sexual assault as defined in C.R.S. 18-3-402, 404, 405, 405.3, or 405.5.
- This pregnancy is the result of incest as defined in C.R.S. 18-6-301- 302.

Description of services and procedure code(s) billed:

Name of facility where abortion services were rendered:

Date service(s) were rendered:

Section III. Signatures

Practitioner Signature	Practitioner Medicaid ID	Date

Attending Practitioner Signature	Attending Practitioner Medicaid ID	Date: