Certification Statement/Case Summary

Abortion Services (Sexual Assault or Incest)

ALL requested information on this form must be completed in its entirety and the form submitted for processing with abortion claims

Section I. Member Information

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

Please check the box(es) below that describes the stated situation as reported by the member (or the member's guardian).

☐ 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 member or guardian 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

Physician's Signature	Physician's Medicaid ID	Date

Attending Practitioner Signature (if applicable)	Attending Practitioner Medicaid ID	Date: