

Certification Statement/Case Summary

Abortion Services (Life Endangering Circumstances)

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: _____

Section II. Practitioner Information

Condition for which procedure was performed:

To save the life of the mother due to a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.

To save the life of the mother based on psychiatric condition.*

*A psychiatric evaluation from a physician, confirming the presence of a life-endangering psychiatric condition, is required for payment. Please submit this documentation as an attachment to this form.

Description of medical condition necessitating abortion:

Description of services and procedure code(s) billed:

Name of facility where abortion services were rendered:

Date service(s) were rendered:

Section III. Additional required documentation

To confirm life endangering circumstances, at least 1 of the following documents must be included with the claim. Please mark the documents submitted:

- Hospital admissions summary
- Hospital discharge summary
- Consultant findings and reports
- Lab results and findings
- Office visit notes
- Hospital progress notes

Section III. Signatures

Practitioner Signature	Practitioner Medicaid ID	Date
_____	_____	_____

Attending Practitioner Signature	Attending Practitioner Medicaid ID	Date:
_____	_____	_____