Certification Statement/Case Summary

Abortion Services (Life Endangering Circumstances)
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: _____

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

Physician's Signature	Physician's Medicaid ID	Date

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