ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: _____

Patient's Medical ID Number: _____

Patient's Address: _____

_____

Physician Certification Statement

I, _____ certify that it was necessary to terminate the pregnancy of _____ _____ for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: _____

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report it attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

The patient's certification is only required in cases of rape or incest.

Patient Certification Statement

I, _____ certify that my pregnancy was the result of an act of rape or incest.

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.