Ohio Department of Medicaid

INSTRUCTIONS FOR COMPLETING ODM 03197
ABORTION CERTIFICATION FORM

In accordance with OAC 5160 -17-01 Abortions, the completion of ODM 03197 "Abortion Certification Form" must be completed in order to receive reimbursement from the Ohio Department of Medicaid.

The form is fillable and available on the Ohio Department of Medicaid website.
http://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03197fillx.pdf

1	**Professional judgment Certification on Medical Necessity** Please check **only one box** to indicate the primary reason for the abortion.
2	**Patient's Name** This field shows the individual's name. The full surname (i.e., family name or "last" name) must be listed. An Initial may be used for the given name ("first" name) or a middle name, but the entire name must match the name on the claim.
3	**Patient's Address - Apartment, Unit or House Number, and Street (or) P.O. Box**
4	**Patient's Address – City, State and Zip Code**
5	**Patient's 12 digit Medicaid Number (Must match exactly as the claim)** This number is also referred to as the Billing Number, Recipient number, MIIS number.
6	**Name of the Physician who performed the abortion** This field shows the name of the physician that performed the procedure.
7	**Physician's Medicaid/NPI Provider Number** This is a 7 digit identification number for Medicaid enrolled providers or 10 digit National Provider Identification (NPI).
8	**Signature [of the Physician] who performed the Abortion** The mark entered in this field must be the legal signature of the individual identified in Field 6.
9	**Date [of Physician's Signature]** This field shows the month, day, and year of the signature identified in Field 8.

Please note: Failure to submit a complete and legible form may result in delay in reimbursement and/or denial.

Ohio Department of Medicaid

ABORTION CERTIFICATION FORM

1. I certify that, on the basis of my professional judgment, this service was necessary because *(check one box only)*		
	1	The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or
	3	The pregnancy was the result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or
	4	The pregnancy was the result of an of incest and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or
	5	The pregnancy was a result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirements; or
	6	The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirements.
PLEASE NOTE: The number indicators beside the empty boxes are for the departmental use only.		

2. Patient's Name	6. Physician's Name *(Please type)*
3. Patient's Address	7. Physician's Medicaid/NPI Provider Number
4. City, State, and Zip Code	8. Physician's Signature
5. Patient's Medicaid Billing Number	9. Date

OAC 5160:3-17-01 requires completion of this from in order to receive Medicaid Reimbursement.