# ABORTION STATEMENT

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

**Patient's Name :** _____

**Patient's Medicaid ID#:** _____

**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 is attached.**

**c. ( ) The patient has certified to me 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 statement is only required in cases of rape or incest.**

## Patient's Certification Statement

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

**(Patient's Name)**

_____ _____

**Patient's Signature** **Date**

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