Abortion Statement

This certification meets Federal Financial Participation (FFP) requirements and must include all of the aforementioned criteria.

Member Information

Member name _____ Humana ID # _____

Medicaid ID _____ Date of birth _____ Telephone _____

Member address (City, state & ZIP) _____

Treating Provider Information

Provider name (include credentials) _____

NPI _____ Telephone _____ Fax _____

Provider address (City, state & ZIP) _____

Contact person name _____ Telephone _____

Email _____ Fax _____

Physician Certification Statement

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

- ❑ 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: _____
- ❑ The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.
- ❑ 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.

Provider signature _____ Date _____

Patient Certification Statement 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.

Member signature _____ Date _____

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

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