



Fax completed form to 855-412-7996

Notification of Medicaid-Covered Abortion

Based on the Hyde Amendment, there are certain requirements for Federally-funded abortions. One of the Federal requirements for Medicaid reimbursement of an abortion is that a physician must certify that a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, which places the woman in danger of death unless an abortion is performed. (Prior to the latest Hyde Amendment requirements, a physician was required to certify only that, in the physician's professional judgment, the life of the woman would be endangered if the fetus were carried to term.)

Member Name: _____

Member ID#: _____

Member Address: _____

Primary Diagnosis for Abortion: _____

Other Diagnoses: _____

The physician must complete this form by certifying one or more of the options below, as applicable, and faxing this form to Health Options at 855-412-7996:

I, _____ (attending physician,) having discussed this matter with the patient, certify that on the basis of my professional judgment, this pregnancy termination is necessary in light of a physical disorder, physical injury or physical illness that places my patient in danger of death unless an abortion is performed.

I, _____ (attending physician,) having discussed this matter with the patient, certify that on the basis of my professional judgment, this pregnancy termination was medically necessary due to a pregnancy resulting from rape.

I, _____ (attending physician,) having discussed this matter with the patient, certify that on the basis of my professional judgment, this pregnancy termination was medically necessary due to a pregnancy resulting from incest.

Physician Signature

NPI#: _____