# CERTIFICATION OF THE DECISION TO TERMINATE PREGNANCY

**Instructions**
This form must be completed by the physician and the patient for the abortion to be covered by the New Hampshire Medicaid Program.

| Patient Name (print or type) | Medicaid Identification Number |
|---|---|
| Patient Street Address | City, State, Zip |

## TO BE COMPLETED BY THE PATIENT

**Section A**

Please check the line(s) that applies to your situation, and sign and date in the space below:

- ☐ The pregnancy is the result of rape.
- ☐ The pregnancy is the result of incest.
- ☐ Check here **only** if you choose to provide documentation of the rape or incest, such as a copy of the police report, and attach a copy of the documentation to this form

_____ _____
Patient Signature Date

## TO BE COMPLETED BY THE PHYSICIAN

**Section B**

- ☐ Check here if the patient is unable to complete Section A.

I certify, on the basis of my professional judgment, that:

- ☐ The mother 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 place the mother in danger of death unless an abortion is performed.**
- ☐ The patient's statement that the pregnancy is the result of rape is accurate.
- ☐ The patient's statement that the pregnancy is the result of incest is accurate.

**Note: Per federal directive, only life endangerment of the mother, not the baby, qualifies. Mental disorders do not qualify.

_____ _____
Attending Physician's Signature Date

_____
Attending Physician's Name (print or type)

Prior authorization is NOT required for abortions, but if you want to request prior authorization, please send or fax the 904 and supporting clinical documentation to the address or fax number below.

Mail to: Medicaid Medical Services Unit
Office of Medicaid Business and Policy
129 Pleasant Street, Brown Bldg
Concord, NH 03301

FAX: 603-271-8194

Claim Payment: Attach the 904 to the claim form **and submit to the fiscal agent for payment**. Do NOT use the above address. A copy of this form and supporting clinical documentation must be retained in the patient record for six (6) years.

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