Ohio Department of Medicaid

ABORTION CERTIFICATION

1. I certify that, on the basis of my professional judgment, this service was necessary for the following reason. *(Check one box only.)*

   ☐ The individual 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 individual in danger of death unless an abortion is performed.

   ☐ 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.

   ☐ The pregnancy was the result of an act 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.

   ☐ The pregnancy was a result of an act of rape and, in my professional opinion, the individual was physically unable to comply with the reporting requirements.

   ☐ The pregnancy was a result of an act of incest and, in my professional opinion, the individual was physically unable to comply with the reporting requirements.

2. Patient's name	6. Physician's name
3. Patient's street address or post office box number	7. Physician's 7-digit Medicaid provider number or 10-digit NPI
4. Patient's city, state, and ZIP Code	8. Physician's signature
5. Patient's 12-digit Medicaid number	9. Date of signature

Notes:

Field 2 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.

Fields six (6) and seven (7) identify the physician who performed the abortion procedure.

In field eight (8), the mark entered must be the legal signature of the physician identified in fields six (6) and seven (7).

In accordance with rule 5160-17-01 of the Administrative Code, this form must be completed before Medicaid payment can be made on a claim. Failure to submit a complete and legible form may result in a delay in payment or denial of the claim.