Abortion Acknowledgement and Certification Form

Recipient Name _____ **Medicaid ID Number**_____ **Date of Service**_____

Recipient Address_____ **City**_____ **State**_____ **Zip Code**_____ **Country**_____

Instructions: Part I and III or IIb and III must be completed and the ATTENDING physician performing the procedure must sign below. Part IIa and IV must be completed by the Medicaid recipient or their legal representative. Completion of this form is required of physicians performing induced abortion procedures. A copy of this form is kept on file in Medicaid Operations. **CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNTIL THIS FORM IS COMPLETED IN FULL AND RECEIVED BY UTAH MEDICAID.**

Section I: IF THE MOTHER'S LIFE IS ENDANGERED, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, the recipient suffers from a physical disorder, physical injury or physical illness (or life endangering physical condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an abortion is performed. The life endangering condition is_____

_____

(attach additional sheets as necessary)

Section II: IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT(or Legal Representative) AND PHYSICIAN:

a._____ RECIPIENT (or Legal Representative) CERTIFICATION: I hereby certify that my(the) current pregnancy resulted from an act of rape or incest.

b._____ PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

I. _____The recipient has verified to me that the rape or incest has been reported to a law enforcement agency.

II. _____Based upon my professional judgment the recipient was and is unable, for physical reasons to report the act of rape or incest.

Section III: The Attending Physician must certify the following:

I further certify:

I. ____ that records to support the certification will be retained and made available to the Department on request consistent with participation as a Medicaid provider.

II. ____ that funds received from the Department are not used to pay or otherwise reimburse, either directly or indirectly, any person agency, or facility for the performance of any induced abortion services unless:
(a) in my professional judgment, the abortion is necessary to save the pregnant woman's life; or
(b) the pregnancy is the result of rape or incest

Attending Physician's Name _____ NPI #_____

Attending Physician's Address_____ City_____ State_____ Zip Code_____

Attending Physician's Signature_____ Date_____

Important Note: Every provider of an induced abortion must perform this procedure in accordance with both state and federal law, and has the responsibility of educating him/herself as to those requirements.

Section IV: Recipient (or Legal Representative) certification:

I, _____ (recipient or legal representative), certify the information I provided on this form is true and accurate._____

Recipient's or Legal Representative's Signature_____ Date _____

Section V: Consent form requirement waiver for induction of fetal demise:
I certify that the documentation has been reviewed and the requirement for a completed Abortion Acknowledgment and Certification Form has been waived in accordance with Utah Medicaid Policy regarding induction of fetal demise.

Utah Medicaid Physician's Signature_____ Date_____

Abortion Acknowledgement and Certification Form – Instructions

Important Note: Every provider of an abortion must perform the procedure in accordance with state and federal law. The provider has the responsibility of educating him/herself as to those requirements.

Instructions	Regulation(s)

1. Circumstances for which an abortion may be approved:
 	
The abortion is performed in accordance with Federal and State law; and is for one of the following circumstances:
 	
• The life of the mother would be endangered; or
• The pregnancy is the result of an act of
  ○ rape or
  ○ incest
 	
Current Medicaid coverage for abortion reimbursement is governed under the Hyde Amendment as set forth in Public Law 111 STAT. 1516 PUBLIC LAW 105–78—NOV.13, 1997.
	42 CFR
	441
	Subpart E
	441.200
	441.201
	441.202
	441.203
	
	UCA
	76-7-102
	76-7-301
	76-5-402
	
	Utah Administrative Rule
	R414

2. INSTRUCTIONS FOR COMPLETING Abortion Acknowledgement and Certification Form: All of the sections below must be completed as follows. For Induction of fetal demise, complete section V only : a. MEDICAID RECIPIENT DEMOGRAPHICS: (May be typed or handwritten.) I. Recipient's Full Name II. Recipient's Medicaid ID number (found on the recipient's Medicaid card) III. Date of service (date abortion is to be performed) IV. Recipient's complete address (country if not USA) b. Section I: IF THE MOTHER'S LIFE IS ENDANGERED: I. Physician must complete this section. II. The physician must provide the medical reason for why the abortion is medically necessary and describe the life endangering condition. c. Section II: IF THE PREGNANCY RESULTED FROM RAPE OR INCEST: I. If applicable, this section must be completed by the recipient and the physician. II. Recipient must initial by "a". III. Physician must initial by "b" and either "I" or "II". d. Section III: The Attending Physician Certification. (No abortion may be performed in this state without agreement by the attending physician.) I. The attending physician must initial statements "I" and "II". II. Print attending physician's name III. Print attending physician's NPI # IV. Print attending physician's address, state and zip code. V. The attending physician must sign and date.	UCA 76-7-303. See Abortion Acknowledge-ment and Certification Form

e. Section IV: Recipient Certification. I. Print recipient's name II. Recipient must sign and date f. Section V: Consent form requirement waiver for induction of fetal demise This section is to be filled out for all cases of induction of fetal demise codes that require the abortion consent form, per Utah Medicaid Policy	
3. Definitions: (1) "Abortion" means the intentional termination or attempted termination of human pregnancy after implantation of a fertilized ovum, and includes any and all procedures undertaken to kill a live unborn child and includes all procedures undertaken to produce a miscarriage. "Abortion" does not include removal of a dead unborn child. (2) "Medical emergency" means that condition which, on the basis of the physician's good faith clinical judgment, so threatens the life of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death (3) "Physician" means a medical doctor licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, a physician in the employment of the government of the United States who is similarly qualified, or an osteopathic physician licensed to practice osteopathic medicine under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act. (4) **"**Rape" means a person commits rape when the actor has sexual intercourse with another person without the victim's consent or if a person has sexual intercourse with a child who is under the age of 14. (5) "Incest" means sexual intercourse between the actor and a person the actor knows has kinship to the actor as a related person (aunt, uncle, mother, brother, father, stepfather, stepmother, ancestor, descendent, nephew, niece, or first cousin.)	42 CFR 441.201 UCA 76-7-301 78A-6-105 76-7-102. 76-7-102 76-6-105 76-5-402.1 76-5-402.3
4. Drugs and devices and termination of ectopic pregnancies: FFP is available in expenditures for drugs or devices to prevent implantation of the fertilized ovum and for medical procedures necessary for the termination of an ectopic pregnancy.	42 CFR 441.207
5. Documentation needed by the Medicaid agency: **a.** FFP is not available in any expenditures for abortions or other medical procedures otherwise provided for under §441.203 if the Medicaid agency has paid without first having received the certifications and documentation specified in that section. **b.** Recordkeeping requirements. Medicaid agencies must maintain copies of the certifications and documentation specified in §441.203 for 3 years under the recordkeeping requirements at 45 CFR 74.20.	42 CFR 441.206 441.208 UCA 76-7-313
6. Fax or mail the Abortion Certification Form: A prior authorization is required before submitting the associated claim(s) to expedite the processing of the Abortion Certification Form and associated claim(s). Fax or mail: **a.** Fax for all abortion requests**: 1-801-536-0472** **b.** Mailing address: **Utah Medicaid** **Attn: Prior Authorization Unit** **P. O. Box 143111** **Salt Lake City, Utah 84114–3111**	