CERTIFICATION FOR INDUCED ABORTION

Michigan Department of Health and Human Services
Health Services

Medicaid, Healthy Michigan Plan, or MIChild payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure (e.g., hospital, anesthesiologist, laboratory) for billing purposes.
- Send a copy of the completed form with the claim. (Refer to the Medicaid Provider Manual, Directory Appendix, Claim Submission/Payment.)

Any questions regarding this form should be referred to Provider Inquiry at 800-292-2550 or e-mail ProviderSupport@michigan.gov .

Beneficiary Name	mihealth Number	Date of Service	
Beneficiary Address (no. & street, apt./lot #, etc.)	City	State	ZIP Code

Appropriate box **must** be checked for payment to be made.

By signing below, I certify that:

☐ **the life of the mother would be endangered if the pregnancy were continued. (List the medical condition(s) that exists.)**

_____

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☐ **the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.**

In cases of rape or incest, was a police report filed?
☐ **YES** ☐ **NO** (If **NO**, explain)

If appropriate, was a report filed with the local MDHHS office?
☐ **YES** ☐ **NO** (If **NO**, explain)

NOTE **Payment for service is not dependent upon a report being filed with the police or the local MDHHS office.**

Physician Name (Type or Print)			Handwritten Signature of Physician	
Address (No. & Street, Ste., etc.)				
City	State	ZIP Code	Date Signed	Provider NPI Number

Authority: Title XIX and Title XXI of the Social Security Act. **Completion**: Is voluntary, but is required if payment from Medicaid, Healthy Michigan Plan, or MIChild programs is sought.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.