Pennsylvania Insurance Department Children's Health Insurance Program

PHYSICIAN CERTIFICATION FOR AN ABORTION

A COPY OF THIS FORM MUST BE ATTACHED TO EACH INVOICE FOR AN ABORTION SERVICE

All information on this form will be kept strictly confidential.

Date of Service:

Patient Name:

Patient Date of Birth:

Patient's Address:

Patient's Insurance ID Number:

PLEASE COMPLETE EITHER PART I OR PART II:

Part I

☐ I certify, on the basis of my professional judgment, that this patient 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 woman in danger of death unless an abortion is performed.

(PHYSICIAN'S SIGNATURE) (DATE)

Physician's Street Address:

Physician's Phone Number:

Part II

A MEMBER STATEMENT FORM MUST ACCOMPANY THIS DOCUMENT IF PART II IS COMPLETED.

☐ This patient is pregnant as a result of: ☐ RAPE ☐ INCEST

☐ I certify that prior to the performance of the abortion, I obtained the attached Member Statement Form signed and dated by the patient.

Complete the following only if applicable:

☐ I certify that, on the basis of my professional judgment, this patient was unable to report the incident of: ☐ RAPE ☐ INCEST and/or the identity of the offender because the patient was: ☐ Physically unable or ☐ Psychologically unable.

(PHYSICIAN'S SIGNATURE) (DATE)

Physician's Street Address:

Physician's Phone Number: