Montana Healthcare Programs
Physician Certification for Abortion Services

Claims submitted to Montana Healthcare Programs for abortion services must include this form with **one section completed** and the signature of the physician at the bottom of the form.

Member Name _____ **Provider Name** _____

Member Address_____**City**_____**State**_____**Zip**_____

1. **If the abortion is necessary to save the member's life, check here.** ☐

In my professional opinion, the member suffers from a physical disorder, physical injury, or physical illness, which may include a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the member in danger of death unless an abortion is performed. My signature appears below. (Attach additional documents as needed.)

2. **If the pregnancy resulted from rape or incest, check here** ☐ **and check either a. or b. below. My signature appears below.**

☐ a. The member has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; **or**

☐ b. Based upon my professional judgement, the member was and is unable, for physical or psychological reasons, to report the act of rape or incest to the appropriate agency.

3. **If the abortion is medically necessary but the member's life is not in danger, check here.** ☐

In my professional opinion, an abortion is medically necessary for the following reasons.
My signature appears below. (Attach additional documents as needed.)

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Physician Signature _____ **Date** _____

The information contained in this form is confidential. This information is used for purposes related to administration of Montana Healthcare Programs and will not be released for any other purpose without the written consent of the member.