POLICY 410, ATTACHMENT C - AHCCCS CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION

OPEN UNTIL 10/25/18

AHCCCS MEMBER INFORMATION

MEMBER NAME: ________________________________ DATE OF BIRTH: ____________________

Last First Middle

ADDRESS: ______________________________

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______________________________ ~~HEALTH PLAN~~CONTRACTOR NAME:

MEMBER AHCCCS ID#: ____________________

FACILITY: ______________________ DATE OF SERVICE: ________ PROCEDURE CODE(S): ________

JUSTIFICATION FOR PREGNANCY TERMINATION (CHECK ONE AND PROVIDE ADDITIONAL RATIONALE):

☐ **LIFE OF MOTHER ENDANGERED** ____

☐ **INCEST** ☐ Police Report Attached

Reported to authorities, pursuant to A.R.S. ~~Section~~ §13-3620 or A.R.S. ~~Section~~ §46-454 Yes _____ No ________

If yes, to what Agency? ______________________ Report #: ____________ Date Filed: ______________

☐ I certify that in my professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirements to report the rape and/or incest to the authorities.

☐ **RAPE** ☐ Police Report Attached

Reported to authorities, pursuant to A.R.S. ~~Section~~ §13-3620 or A.R.S. ~~Section~~ §46-454 Yes _____ No ________

If yes, to what Agency? ______________________ Report #: ____________ Date Filed: ____________

☐ I certify that in my professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirements to report the rape and/or incest to the authorities.

☐**MEDICALLY NECESSARY (CHECK ONE)**

- ☐ Creating a serious physical or behavioral health problem for the pregnant member
- ☐ Seriously impairing a bodily function of the pregnant member
- ☐ Causing dysfunction of a bodily organ or part of the pregnant member
- ☐ Exacerbating a health problem of the pregnant member
- ☐ Preventing the pregnant member from obtaining treatment for a health problem

COMPLETE ONLY WITH THE USE OF MIFEPRISTONE (MIFEPREX OR RU-486)

Duration of Pregnancy: ________ Days

Date IUD Removed: ______________________
(if applicable)

Date Mifepristone Given: ____________________

Date Misoprostol Given: ____________________

☐Documentation of Confirmed Termination is Attached

Physician Signature: ____ Date: ______________

Physician's Printed Name: __________________ Physician's Phone: ___________ Fax: __________

Prior Authorization Number: ______________________________ Date: ________________

Denial Reason: ______________________________________ Date: __________________

Contractor Medical Director/AHCCCS Chief Medical Officer Signature: ______________________