

AHCCCS MEDICAL POLICY MANUAL

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

AHCCCS MEMBER INFORMATION

ME	MBE	R NAME:							
		LAST	FIRST	MIDDL		DATE OF BIRTH			
ADDRESS			CONTRACTOR NAME	M	MEMBER AHCCCS ID#				
PLACE OF PROCEDURE			DATE OF SERVICE	P	PROCEDURE CODE(S)				
			TION FOR PREGNANCY TE		V)				
1.		LIFE OF BIRTHING MOTHER END	DANGERED						
2.		INCEST							
		☐ Reported to authorities, pursuant to A.R.S. §§ 13-3620 or 46-454							
		☐ Police Report Attached			YES	NO			
		IF YES, TO WHAT AGENCY?		REPORT #:	DATE FILED				
		☐ I certify that in my professional opinion, the woman was unable, for physical or psychological reasons to comply with the requirements to report the rape and/or incest to the authorities.							
3.		RAPE							
		☐ Police Report Attached			YES	NO			
		IF YES, TO WHAT AGENC	Y?	REPORT#		DATE FILED			
		I certify that in my professional to comply with the requiremen				ological reasons,			

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4.	4. MEDICALLY NECESSARY/HEALTH OF THE MOTHER ENDANGERED (IF CHECKED, MUST ALSO CHOOSE ONE OF THE FOLLOWING AS THE PRIMARY REASON)										
[Creating a serious physical or behav health problem for the pregnant wo			Exacerbating a health problem woman.	of the pregnant					
ſ		Seriously impairing a bodily function pregnant woman.	of the		Preventing the pregnant obtaining treatment for a hear						
Ī		Causing dysfunction of a bodily orga of the pregnant woman.	n or part								
COMPLETE ONLY WITH THE USE OF MEDICATIONS											
			_								
		NAME OF MEDICATION(S) (IF A	PPLICABLE)		DATI	E GIVEN					
		NAME OF MEDICATION(S) (IF A	PPLICABLE)		DATE	GIVEN					
		NAME OF MEDICATION(S) (IF A	PPLICABLE)	DATE GIVEN							
CONFIRMATION OF TERMINATION AND DURATION OF PREGNANCY (REQUIRED)											
Duration of Pregnancy: Days.											
□ DOCUMENTATION OF CONFIRMED TERMINATION IS ATTACHED											
	PH	YSICIAN SIGNATURE			DATE						
Р	HYS	SICIAN PRINTED NAME		PH	YSICIAN PHONE	FAX					
PRIO	R A	UTHORIZATION NUMBER			DATE						
FOR CONTRACTOR AND AHCCCS (FOR FFS MEMBERS) USE ONLY											
	Α	PPROVED	С] [DENIED						
	DENIAL REASON (IF APPLICABLE)	1		DATE (OF APPROVAL/D	PENIAL)						
CONTRACTOR MEDICAL DIRECTOR (OR AHCCCS MEDICAL DIRECTOR SIGNATURE FOR FFS MEMBERS)											

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