ABORTION NECESSITY

I, _____ (name of physician), certify on the basis of my professional judgment, the pregnancy of _____ (name of patient) of _____ (address),

☐ is suffering from a physical disorder, physical injury or physical illness, including a life-endangering physical condition, caused by or arising from the pregnancy itself.

☐ is a result of rape.

☐ is a result of incest.

_____ _____
(Signature of Patient) (Date 00/00/0000)

_____ _____
(Signature of Physician) (Date 00/00/0000)

_____
(Physician's Address)

_____
(Physician's NPI)

This form must be completed in its entirety.
Incomplete information may result in the claim being denied.