

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

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**NC Medicaid
Therapeutic and Non-therapeutic
Abortions**

**Medicaid and Health Choice
Clinical Coverage Policy No.: 1E-2
Amended Date: March 15, 2019**

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1.0 Description of the Procedure, Product or Service

1.1 Definitions

Therapeutic Abortion

A therapeutic abortion is the termination of a pregnancy where fetal heart tones are present at the time of the abortive procedure. The termination of a pregnancy may be induced medically (prostaglandin suppositories, etc.) or surgically (dilation and curettage, etc.). This includes the delivery of a non-viable (incapable of living outside the uterus) but live fetus, if labor was augmented by pitocin drip, laminaria suppository, etc.

Non-Therapeutic Abortion

A non-therapeutic abortion is any termination of a pregnancy where there has been no manual or surgical interruption of that pregnancy (missed, incomplete, spontaneous, etc.).

Qualified Physician

Qualified physician means the same as found in NCGS 14-45.1(g).

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover therapeutic and non-therapeutic abortions when the procedure is medically necessary and provided in accordance with federal and state laws and regulations.

3.2.2 Criteria for Therapeutic Abortions

Medicaid and NCHC shall cover therapeutic abortions when:

- a. a woman 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, as certified by a physician, place the woman in danger of death unless an abortion is performed; or
- b. the pregnancy is the result of an alleged act of incest; or
- c. the pregnancy is the result of an alleged act of rape.

3.2.3 Criteria for Non-Therapeutic Abortions

Medicaid and NCHC shall cover non-therapeutic abortions when the termination of a pregnancy occurs without any manual or surgical interruption of that pregnancy (missed, incomplete, spontaneous, etc.).

3.2.4 When an Abortion Is Not Unlawful

Refer to NCGS 14-45.1 for established provisions that govern the coverage of abortions.

Note: Refer to **Section 4.0** of this document for circumstances when Medicaid does not cover therapeutic abortions that are lawful.

3.2.5 Medicaid Additional Criteria Covered

None Apply.

3.2.6 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Procedures, products, and services related to this policy are not covered when the federally mandated requirements are not met.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.

3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall not require prior approval for therapeutic and non-therapeutic abortions.

5.2 Therapeutic Abortion

5.2.1 Life-Threatening Conditions

Federal regulations require Medicaid agencies to obtain certification (refer to **Subsection 5.3**) in writing from the physician performing the abortion attesting to the fact that in his/her professional judgment that the life of the mother would be endangered if the fetus were carried to term.

- a. If the abortion was necessary to save the life of the mother—regardless of whether the pregnancy was a result of rape or incest—the medical diagnosis and health records must support the certification.
- b. An appropriate diagnosis code, legally induced abortion, must be indicated on the claim.
- c. Health records supporting the certification must be submitted to DHHS fiscal contractor, along with the abortion statement. Health record documentation may include history, physical, operative report, office admission history notes and physical, discharge summary, ultrasound report, consult reports and pathology reports.
- d. The requirements of parental consent for a minor (see **Section 5.4**) do not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

5.2.2 Incest

Medicaid and NCHC require the physician performing the abortion to submit certification (refer to **Subsection 5.3**) in writing attesting to the fact that in his/her professional judgment the beneficiary was a victim of incest.

- a. When submitting a claim for an abortion performed due to incest, an ICD-10-CM diagnosis code must be billed indicating the perpetrator of the assault, in addition to a diagnosis code indicating rape.
- b. The health record documentation supporting the certification must be available for review, if necessary.
- c. The requirements of parental consent for a minor (refer to **Subsection 5.4**) do not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

5.2.3 Rape

Medicaid and NCHC require the physician performing the abortion to submit certification (refer to **Subsection 5.3**) in writing attesting to the fact that in his/her professional judgment the beneficiary was a victim of rape.

- a. An appropriate ICD-10-CM diagnosis codes for rape, must be indicated on the claim.
- b. The health record documentation supporting the certification must be available for review, if necessary.
- c. The requirements of parental consent for a minor (refer to **Subsection 5.4**) do not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

5.3 The Abortion Statement

Providers must certify in writing that in their professional judgment a therapeutic abortion was performed for one of the reasons listed in **Subsection 5.2**. The primary physician or surgeon is responsible for obtaining the abortion statement. All claims will deny until the appropriate statement is on file.

The abortion statement must be printed on the provider's professional letterhead and include the following information (numbers refer to keyed items on the example statement in **Attachment C**):

1. Beneficiary's name as it appears on the beneficiary's identification card.
2. Beneficiary's address.
3. The beneficiary's identification number.
4. The gestational age of the fetus at the time of the abortion.
5. Item #5 must be checked if the therapeutic abortion was necessary due to 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 was performed.
6. Item #6 must be checked if the pregnancy was a result of rape.
7. Item #7 must be checked if the pregnancy was a result of incest.
8. **The physician's name** (Printed).
9. **The physician's signature.**
10. The physician's NPI number.
11. **The date the certification was signed.**

Note: All areas are required to be completed, if applicable. **Fields in bold print cannot be altered.**

Note: If item #5 is checked, indication for the abortion necessary to save the life of the mother must be documented in the health record. Health records supporting the certification must be submitted to DHHS fiscal contractor, along with the abortion statement. Health record documentation may include history, physical, operative report, office admission history notes and physical, discharge summary, ultrasound report, consult reports and pathology reports.

Refer to **Attachments B and C** for an example of the abortion statement and submittal instructions.

5.4 Parental Consent for a Minor

Providers shall comply with requirements for parental consent as found in NCGS 90-21.7.

Note: The requirements of parental consent do not apply when a medical emergency exists, as indicated in NCGS 90-21.9.

Note: By submitting the abortion statement for a minor, the physician is verifying that the requirements of **Subsection 5.4** have been met.

5.5 Name Change Statement

A signed name change statement must be provided to DHHS fiscal contractor when the beneficiary's name listed on the claim is different than the name on the abortion statement. The name change statement must verify that the names are for the same person. This statement must be written on the provider's office letterhead. (See Attachment B(D), Instructions for Completing the Name Change Form.)

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Qualified physician means the same as found in NCGS 14-45.1(g).

Providers shall comply with the following laws and regulations: NCGS 14-45.1(g), NCGS 90-21.81(5), 42 CFR 441.201.

6.2 Provider Certifications

None Apply.

6.3 Right of Refusal

NCGS 14-45.1 indicates that a physician licensed to practice medicine in North Carolina or any nurse who shall state an objection to an abortion on moral, ethical, or religious grounds, is not required to perform or participate in medical procedures that result in an abortion. The refusal of such physician to perform or participate in these medical procedures shall not be a basis for damages for such refusal, or for any disciplinary or any other recriminatory action against such physician.

NCGS 14-45.1 further indicates that a hospital or any other health care institution is not required to perform an abortion or to provide abortion services.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 1993

Revision Information:

Date	Section Revised	Change
5/1/07	Attachment A	Added UB-04 as an accepted claims form.
7/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
3/1/12	Section 5.3	Revised Subsection wording from 5.1 to 5.2
3/1/12	Attachment A	Changed UB-92 to UB-04, deleted 603 in hospital section so 630 can be billed with 69.59 and 69.09, added information about revenue code billing.
3/1/12	Attachment B	Added Attachment B.
3/1/12	Attachment C	Added Physician NPI number to consent form, Changed "Medicaid" to "Recipient" Identification Number.
3/1/12	Attachment D	Added Attachment D.
3/1/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1E-2 under Session Law 2011-145 § 10.41.(b)
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
01/01/2016	Section 3.2.4	Revised information due to change in State legislative session law.

Date	Section Revised	Change
04/01/2017	Sections 1.1 and 6.1	Added definition of a qualified physician, as defined in NCGS 14-45.1(g)
08/01/2017	Throughout	Changed medical records to health records.
08/01/2017	Section 3.2.2	Added “or”.
08/01/2017	Section 3.2.4	Added instruction to refer to NCGS 14-45.1 and removed end dated website. Added “of this document.”
08/01/2017	Section 5.2.1(c) and 5.3, Attachment B	Clarified acceptable health records that may be submitted when an abortion was performed to save the life of the mother.
08/01/2017	Section 5.2.2 and 5.2.3	Removed ICD-10 diagnoses and added information related to claim submission.
08/01/2017	Section 5.3	Clarified instructions for completing the abortion statement.
08/01/2017	Section 5.4	Revised instruction for providers to refer to NCGS 90-20.7 for requirements for parental consent and NCGS 90-21.9.
08/01/2017	Section 5.5	Added instruction, related to when name change statement is required.
08/01/2017	Section 6.3	Added “an.”
08/01/2017	Attachment A	Updated therapeutic and non-therapeutic procedure and diagnosis list. Removed instructions related to CPT procedure codes 59160 and 58120. Added instructions for outpatient claims billing. Included information related to mailing abortion statements to DHHS fiscal contractor.
08/01/2017	Attachment B	(A) Added title “Completing the Form.” Added instruction related to abortion statement submission. The use of initials is unacceptable. (B) Added mailing address for providers to submit the abortion statement. (C) (D) Added instruction related to submission of the name change statement.
08/01/2017	Attachment C	Added updated abortion statement (DMA-3214) and website where providers may print appropriate abortion statement.
10/01/2017	Attachment A (B)	Updated ICD 10 procedure code list.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code

Providers are required to select the most specific billing code that accurately describes the service(s) provided.

Non-Therapeutic Abortions			
Claim Type	Procedure	Diagnosis	Abortion Statement Required
Physician (CMS-1500)	59870	O01.0, O01.1, O01.9	No
	59812, 59820, 59821, 59830, 01965, 88305	O02.1, O03.39, O03.4, O03.89, O03.9	No
Hospital (UB-04)	0UC90ZZ, 0UC93ZZ, 0UC94ZZ, 10D17ZZ, 10D18ZZ, 0UDB7ZZ, 0UDB8ZZ	O01.0, O01.1, O0.19	No
	10D17ZZ, 10D18ZZ, 10D17Z9, 10D18Z9	O02.1, O03.39, O03.4, O03.89, O03.9	No

Therapeutic Abortions			
Claim Type	Procedure	Diagnosis	Abortion Statement Required
Physician (CMS-1500)	59200, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 01966, 88304	O04.80, O04.89, O073.0, O073.9, O07.4, Y07.11, Y07.13, Y07.410, Y07.430, Y07.435, Y07.490, Y07.499, T7421XA, T7422XA	Yes (Diagnosis for Life-threatening conditions require an abortion statement and records)
Hospital (UB-04)	10A07ZZ, 10A08ZZ, 10A00ZZ, 10A03ZZ, 10A07ZX, 10A04ZZ, 10A07ZW, 10A07Z6	O04.80, O04.89, O073.0, O073.9, O07.4, Y07.11, Y07.13, Y07.410, Y07.430, Y07.435, Y07.490, Y07.499, T7421XA, T7422XA	Yes (Diagnosis for Life-threatening conditions require an abortion statement and records)

- a. Therapeutic and non-therapeutic abortion outpatient hospital claim(s) require a HCPCS code.
- b. The treatment of septic abortion, can be considered a therapeutic or non-therapeutic abortion. When billed with a therapeutic abortion diagnosis code health record documentation and an abortion statement must be submitted with the claim or mailed to DHHS fiscal contractor to determine if federal guidelines are met.

Note: Providers shall use the most appropriate revenue code that accurately describes the service(s) provided.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient, Outpatient Hospital, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

Attachment B: Instructions for Completing the Abortion Statement

A. Completing the Form

The abortion statement must be printed on the provider's professional letterhead. All areas are required to be completed, if applicable. **Fields in bold print cannot be altered.** This guide will assist in correct completion of the abortion statement and should help to decrease the number of denials related to errors in completing the form.

1. Name of beneficiary as it appears on the beneficiary identification card.
2. Address of the beneficiary.
3. Beneficiary identification number as it appears on the beneficiary identification card.
4. Gestational Age of the fetus at the time of the abortion.
5. Check this area if the abortion was necessary due to 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 was performed.
6. Check this area if the abortion was necessary due to an act of rape.
7. Check this area if the abortion was necessary due to an act of incest.
8. **Printed version of the physician's name that performed the procedure.**
9. **Signature of the physician performing the procedure, including first and last name. Initials used for the first or last name will result in abortion statement denial.**
10. Physician NPI number.
11. **Date the physician signed the statement.**

Note: If Item #5 is checked on the abortion statement, indication that the abortion was necessary to save the life of the mother must be documented in the health record. Health records supporting the certification must be submitted to DHHS fiscal contractor, along with the abortion statement. Health record documentation may include history, physical, operative report, office admission history notes and physical, discharge summary, ultrasound reports, consult reports and pathology reports.

B. Submitting Abortion Statements

Abortion statements and health records, if applicable, may be submitted with the claim in NCTracks or may be mailed to:

CSRA
PO Box 30968
Raleigh, NC 27622

C. Name Change Policy for Surgical Procedures

If the be beneficiary's name on the claim and the name on the abortion statement are different, a signed name change statement verifying that they are the same person must be included (refer to example below).

D. Name Change Statement (Example)

The name change statement must be written on the provider's office letterhead.

Dr. Any Provider
101 Any Hwy
Any City NC 22222
Beneficiary identification number: 88888888T

To Whom It May Concern:

Jane Beneficiary has changed her name to Jane Doe.

Dr. Any Provider (Signature of representative at provider's office is required)

Attachment C: The Abortion Statement

The Abortion Statement Form is available at
<https://dma.ncdhhs.gov/abortion-statement>

The entire wording shown below must copied into the provider's professional letterhead. **Bolded fields cannot be altered.** The abortion statement form and appropriate medical record documentation must be submitted to DHHS fiscal contractor for review.

Abortion Statement

1. Beneficiary's Name: _____
2. Beneficiary's Address: _____

3. Beneficiary's Identification Number: _____
4. Gestational Age: _____

Based on my professional judgment, I certify that I performed an abortion on the above-named beneficiary for the following reason:

5. The abortion was necessary due to 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 was performed.
6. Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
7. Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

My signature on this statement is an attestation that the requirements were met and documentation is on file.

8. _____ 9. _____
Physician's Name (Printed) Physician's Signature

10. _____ 11. _____
Physician's NPI Physician's Signature Date

DMA-3214