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| **AHCCCS MEMBER INFORMATION** |
| **MEMBER NAME:** |  |  |  |  |  |  |  |
|  | *LAST* |  | *FIRST* |  | *MIDDLE* |  | *DATE OF BIRTH* |
|  |  |  |  |  |
| *ADDRESS*  |  | *CONTRACTOR NAME* |  | *MEMBER AHCCCS ID#* |
|  |  |  |  |  |
| *PLACE OF PROCEDURE* |  | *DATE OF SERVICE*  |  | *PROCEDURE CODE(S)* |

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| **JUSTIFICATION FOR PREGNANCY TERMINATION****(CHECK ONLY ONE OF THE NUMERATED OPTIONS BELOW)** |
| 1. |[ ]  **LIFE OF MOTHER ENDANGERED** |
| 2. |[ ]  **INCEST** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Reported to authorities, pursuant to ARS 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. |

|  |  |
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| 3. |[ ]  **RAPE** |
| [ ]  | Reported to authorities pursuant to ARS 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. |
| 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 behavioral health problem for the pregnant mother. |[ ]  Exacerbating a health problem of the pregnant mother. |
|[ ]  Seriously impairing a bodily function of the pregnant mother. |[ ]  Preventing the pregnant mother from obtaining treatment for a health problem.  |
|[ ]  Causing dysfunction of a bodily organ or part of the pregnant mother. |  |  |

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| **COMPLETE ONLY WITH THE USE OF MEDICATIONS** |
|  |  |  |
| *NAME OF MEDICATION(S) (IF APPLICABLE)* |  | *DATE GIVEN* |
|  |  |  |
| *NAME OF MEDICATION(S) (IF APPLICABLE)* |  | *DATE GIVEN* |
|  |  |  |
| *NAME OF MEDICATION(S) (IF APPLICABLE)* |  | *DATE GIVEN* |

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| **CONFIRMATION OF TERMINATION AND DURATION OF PREGNANCY (REQUIRED)** |
| Duration of Pregnancy: |  | Days. |
|[ ]  **DOCUMENTATION OF CONFIRMED TERMINATION IS ATTACHED** |
|  |  |  |  |  |
| *PHYSICIAN SIGNATURE* |  | *DATE* |  |  |
|  |  |  |  |  |
| *PHYSICIAN PRINTED NAME* |  | *PHYSICIAN PHONE* |  | *FAX* |
|  |  |  |  |  |
| *PRIOR AUTHORIZATION NUMBER* |  | *DATE* |  |  |
| **FOR CONTRACTOR AND AHCCCS (FOR FEE-FOR-SERVICE (FFS) MEMBERS) USE ONLY** |
|[ ]  **APPROVED** |  |[ ]  **DENIED** |
|  |  |  |  |
|  | *DENIAL REASON (IF APPLICABLE)* |  |  | *DATE (OF APPROVAL/DENIAL)* |
|  |
| *CONTRACTOR MEDICAL DIRECTOR**(OR AHCCCS MEDICAL DIRECTOR SIGNATURE FOR FFS MEMBERS)* |