|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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)* | | | |

|  |  |  |
| --- | --- | --- |
| **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)* | | | | | | | | | | | |