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| --- | --- |
| **CONTRACTOR NAME AND LINE OF BUSINESS**:  |  |
| **REPORTING DATE**: |  |
| **NAME OF INDIVIDUAL COMPLETING FORM**:  |  |  |  |
|  | ***NAME*** |  | ***TITLE*** |

When terminations have been authorized by the Contractor, the following information shall be provided:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **AHCCCS MEMBER ID** | **\*REASON** | **\*\*AGE** | **RATE CODE** | **PROCEDURE CODE** | **DATE OF SERVICE** |
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| **CHOOSE ONE OF THE FOLLOWING CODES:** |
| **\*Reasons for Termination** | \*\***Age/Condition** |
| A. | Life of mother endangered | a) | Under 18 years of age |
| B. | Result of Incest | b) | Incapacitated, over 18 years of age |
| C. | Result of Rape | c) | 18 years of age and older |
| D. | Medically Necessary |  |  |

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| **FOR EACH AUTHORIZED PREGNANCY TERMINATION, ATTACH TO THIS REPORT THE FOLLOWING:** |
|  |
| 1. | A copy of the written consent.  |
| 2. | A copy of the Prior Authorization (PA) request. |
| 3. | A copy of the AHCCCS Certificate of Necessity for Pregnancy Termination form. |
| 4. | A copy of the Verification of Diagnosis by Contractor for Pregnancy Termination request. |
| 5. | A copy of the official incident report, when rape or incest is involved unless the treating physician certifies, in their professional opinion, that the member was unable for physical or psychological reasons to comply with the requirements to report the rape and/or incest to the authorities |
| 6. | Clinical documentation demonstrating that the pregnancy termination occurred. |
| 7. | Clinical reports and medical documentation supporting justification for pregnancy termination. |

**REPORTS AND SUPPORTING DOCUMENTATION SHALL BE SUBMITTED AS SPECIFIED IN CONTRACT.**

**ANY ADDITIONAL INFORMATION DISCOVERED AFTER SUBMISSION MUST BE SUBMITTED TO AHCCCS UPON RECEIPT FOR REVIEW AND CONSIDERATION.**