POLICY 410, ATTACHMENT C, AHCCCS CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION

AHCCCS MEMBER INFORMATION

MEMBER NAME: _____ DATE OF BIRTH: _____
Last First Middle

ADDRESS: _____

_____ HEALTH PLAN: _____

_____ MEMBER AHCCCS ID#: _____

FACILITY: _____ DATE OF SERVICE: _____ PROCEDURE CODE(S): _____

JUSTIFICATION FOR PREGNANCY TERMINATION (CHECK ONE AND PROVIDE ADDITIONAL RATIONALE):

☐ **LIFE OF MOTHER ENDANGERED** _____

☐ **INCEST** ☐ Police Report Attached

Reported to authorities, pursuant to A.R.S. Section 13-3620 or A.R.S. Section 46-454 Yes _____ No _____

If yes, to what Agency? _____ Report #: _____ Date Filed: _____

☐ I certify that in my professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirements to report the rape and/or incest to the authorities.

☐ **RAPE** ☐ Police Report Attached

Reported to authorities, pursuant to A.R.S. Section 13-3620 or A.R.S. Section 46-454 Yes _____ No _____

If yes, to what Agency? _____ Report #: _____ Date Filed: _____

☐ I certify that in my professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirements to report the rape and/or incest to the authorities.

☐ **MEDICALLY NECESSARY (CHECK ONE)**

- ☐ Creating a serious physical or behavioral health problem for the pregnant member
- ☐ Seriously impairing a bodily function of the pregnant member
- ☐ Causing dysfunction of a bodily organ or part of the pregnant member
- ☐ Exacerbating a health problem of the pregnant member
- ☐ Preventing the pregnant member from obtaining treatment for a health problem

COMPLETE ONLY WITH THE USE OF MIFEPRISTONE (MIFEPREX OR RU-486)

Duration of Pregnancy: _____ Days

Date IUD Removed: _____ (if applicable)

Date Mifepristone Given: _____

Date Misoprostol Given: _____

☐ Documentation of Confirmed Termination is Attached

Physician Signature: _____ Date: _____

Physician's Printed Name: _____ Physician's Phone: _____ Fax: _____

Prior Authorization Number: _____ Date: _____

Denial Reason: _____ Date: _____

Contractor Medical Director/AHCCCS Chief Medical Officer Signature: _____

Effective Dates: 09/01/09, 09/01/11, 10/01/13, 09/01/16, 01/10/18
Revision Dates: 09/01/09, 09/01/11, 10/01/13, 09/01/16, 11/16/17