

## Abortion Certification

I hereby certify that in my professional judgment an abortion is necessary for the following patient: \_\_\_\_\_ whose address is \_\_\_\_\_  
Beneficiary's Name

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Because:

- The pregnancy is the result of an act of rape or incest.
- The 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, which would place the woman in danger of death unless the abortion is performed.

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

TO THE PHYSICIAN, HOSPITAL, CLINIC, ETC.: A copy of this certification form, duly executed, must be attached to any claim submitted for payment from Vermont Medicaid for services related to an abortion.

## Abortion Certification

I certify that the abortion I performed on \_\_\_\_\_  
Beneficiary's Name

on \_\_\_\_\_, was necessary in the light of all factors, physical, emotional,  
Date

psychological, familial, the patient's age, relevant to the health-related well-being of the patient.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

TO THE PHYSICIAN, HOSPITAL, CLINIC, ETC.:

A copy of this certification form, duly executed, must be attached to any invoice submitted for payment from Vermont Medicaid for an abortion considered medically necessary.

No certification is required for termination of ectopic pregnancy other than proper diagnosis code on the billing form.