

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.