



**INSTRUCTIONS FOR COMPLETING  
"CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION"**

1. **Date of Service:** The date the abortion was performed. This can be typed or handwritten.
2. **Individual's Full Name:** The name of the individual can be typed or handwritten.
3. **Individual's Date of Birth:** Individual's date of birth can be typed or handwritten.
4. **Individual's Address:** Individual's complete address including street, city, state, and zip code. This can be typed or handwritten.
5. **Condition:** Mark the block indicating the applicable reason for the abortion. This can be typed or handwritten.
6. **Supporting Documentation:** Mark the block that applies to the type of supporting documentation. This can be typed or handwritten.
7. **Physician NPI# and Address:** The physician's NPI# and complete address including street, city, state, and zip code. This can be typed or handwritten.
8. **Physician Signature/Date:** The physician must sign his/her name and date simultaneously in his/her own handwriting after the procedure.

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## TennCare, a Division of Health Care Finance and Administration

Rev. April 24, 2015

### CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

**DATE OF SERVICE:** \_\_\_\_\_ 1 \_\_\_\_\_

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Individual's Full Name: \_\_\_\_\_ 2 \_\_\_\_\_

Individual's Date of Birth: \_\_\_\_\_ 3 \_\_\_\_\_

Individual's Address: \_\_\_\_\_ 4 \_\_\_\_\_  
Street Address City State Zip Code

for the following reason:

**(CHECK ONE)** \_\_\_\_\_ 5

There is credible evidence to believe the pregnancy is the result of rape or incest.

The abortion is medically necessary as 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 that would place the woman in danger of death unless an abortion is performed.

**SUPPORTING DOCUMENTATION:** \_\_\_\_\_ 6

**(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)**

Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.

Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.

Medical records documenting the lifesaving nature of the abortion.

Other (Please Specify): \_\_\_\_\_

**PHYSICIAN PERFORMING ABORTION:**

Physician NPI#: \_\_\_\_\_ 7 \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ 8 \_\_\_\_\_ Date: \_\_\_\_\_

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