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

Rev. April 24, 2015

## CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

**DATE OF SERVICE:** _____

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

Individual's Full Name: _____

Individual's Date of Birth: _____

Individual's Address: _____ _____ _____ _____
Street Address City State Zip Code

for the following reason:

**(CHECK ONE)**

- ❑ 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:**

**(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#: _____
Physician Address: _____
_____
Physician Signature**:** _____ Date: _____