COLORADO
Department of Health Care Policy & Financing

Certification Statement/Case Summary

Abortion Services (Life Endangering Circumstances)

All requested information on this form must be completed in its entirety and the form submitted for processing with the abortion claims.

Section I. Member Information

1. Member Health First Colorado ID: _____
2. Member Name:_____
3. Member Address: _____
4. Age of Member:_____5. Gestational Age of Fetus / Weeks of Pregnancy: _____

Section II. Physician Information

Condition for which procedure was performed:

☐ To save the life of the mother due to a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.

☐ To save the life of the mother based on psychiatric condition. *
*A psychiatric evaluation from a physician, confirming the presence of a life-endangering psychiatric condition, is required for payment. Submit this documentation as an attachment to this form.

☐ I certify that a life-endangering condition caused by or arising from the pregnancy itself places the woman in danger of death unless an abortion is performed.

Signature and ID of Certifying Physician:

Physician's Signature _____

Physician's Health First Colorado ID _____

Date: _____

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Practitioner Needs to Complete EITHER: 1) Section II.a and II.a(i) OR 2) Section II.b below, as applicable:

Section II.a: Complete the information requested below, when a surgical abortion is provided:

Description of medical condition necessitating abortion:

_____

Description of services and procedure code(s) billed:

_____

Name of health care facility where abortion services were rendered:

_____

Date service(s) were rendered: _____

Section IIa(i). Additional Required Documentation

To confirm life endangering circumstances, at least one (1) of the following documents must be included with the claim. Check the documents submitted:

- ☐ Hospital admissions summary
- ☐ Hospital discharge summary
- ☐ Consultant findings and reports
- ☐ Lab results and findings
- ☐ Office visit notes
- ☐ Hospital progress notes

Section II.b: Complete the information requested below, when a medication (Mifepristone and/or Misoprostol) abortion is provided.

Report: 1) how the medication(s) were provided/dispensed and 2) which medication(s) were dispensed.

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Check all appropriate boxes:

Medication Provision:

☐ Prescription to be filled and dispensed by a contracted Pharmacy in compliance with REMS protocol.

Medication(s) Dispensed: ☐ Mifepristone ☐ Misoprostol

OR

☐ Prescription(s) provided and administered by a contracted Clinician/Practitioner in compliance with REMS protocol.

Medication(s) Dispensed: ☐ Mifepristone (S0190) ☐ Misoprostol (S0191)

Additional Risk Evaluation & Mitigation Strategy (REMS) information and signature are required below.

☐ Health First Colorado member requested a medication abortion.

Description of service(s) and procedure code(s) billed for service provision:

_____

Name of health care facility where the medication abortion was rendered (in person) or provided (via telemedicine):

_____

Date(s) service(s) were rendered:

Date of Initial Visit (in person or via telemedicine) with medication(s) prescribed, administered and/or dispensed:

_____

☐ S0199 billed: this code includes a bundle of services required for a medication abortion. All included services have been performed and recorded in medical records, as required.

Date(s) scheduled for follow-up with provider: _____

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Mifepristone Risk Evaluation & Mitigation Strategy (REMS) Program:

☐ I certify that all requirements under the Mifepristone REMS Program have been and will be met.

Signature and ID of Certified REMS Mifepristone Prescribing Contractor:

Practitioner's Signature _____

Practitioner's Health First Colorado ID _____

Date _____

Attending Practitioner Signature _____

Attending Practitioner Health First Colorado ID (if applicable) _____

Date: _____

Section IV: Rendering Physician's Signatures

Physician/Clinician's Signature_____

Physician/Clinician's Health First Colorado ID _____

Date _____

Attending Practitioner Signature _____

Attending Practitioner Health First Colorado ID_____

Date _____