Certification Statement/Case Summary

Abortion Services (Sexual Assault or Incest)

ALL requested information on this form must be completed in its entirety and the form submitted for processing with 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: _____

Please check the box(es) below that describe(s) the stated situation as reported by the member (or the member's guardian).

☐ Pregnancy resulting from sexual assault (rape)

☐ Pregnancy resulting from incest

Section II. Practitioner Information (to be completed by the practitioner)

I was advised by the member or guardian that:

☐ This pregnancy is a result of sexual assault as defined in C.R.S. 18-3-402, 404, 405, 405.3, or 405.5.

☐ This pregnancy is the result of incest as defined in C.R.S. 18-6-301- 302.

Practitioner Needs to Complete EITHER Section II.a OR Section II.b below, as applicable:

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

Description of services and procedure code(s) billed:_____

_____

_____

Name of licensed facility where the abortion services were rendered:

_____

Date service(s) were rendered: _____

Section II.b: Complete the information requested below, when a medical (Mifeprex + Misoprostol) abortion is provided. Additional Risk Evaluation & Mitigation Strategy (REMS) information and signature are required below.

☐ Health First Colorado member requested a medically-induced method for this abortive procedure.

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

_____

_____

Name of licensed facility where the medically-induced abortion services were rendered:

_____

Date(s) service(s) were rendered:

Date of Initial Visit (medications prescribed/dispensed):

_____

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

Date(s) Scheduled for Follow-up Visit(s):

_____

_____

Mifeprex Risk Evaluation & Mitigation Strategy (REMS) Program:

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

Signature and ID of Certified Mifeprex Prescriber:

Physician's Signature	Physician's Health First Colorado ID	Date
_____	_____	_____
Attending Practitioner Signature (if applicable)	Attending Practitioner Health First Colorado ID	Date
_____	_____	_____

Section III. Rendering Physician's Signatures

Physician's Signature	Physician's Health First Colorado ID	Date
_____	_____	_____
Attending Practitioner Signature (if applicable)	Attending Practitioner Health First Colorado ID	Date
_____	_____	_____