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 Medicaid ID: ________________________
2. Member Name:____
3. Member Address: ____
4. Age of Member:______
5. 5. Gestational Age of Fetus / Weeks of Pregnancy: __________________________

Section II. Practitioner 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 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

COLORADO
Department of Health Care Policy & Financing

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 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 medical (Mifepristone + 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 health care facility where the medically-induced abortion services were rendered (in person) or provided (via telemedicine):

____

Date(s) service(s) were rendered: ___________________________________

Date of Initial Visit (in person or telemedicine) with medications dispensed or prescribed:

____

☐ 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 with provider: __________________________

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 Mifepristone Prescriber:

______________________________	____________________	____________
Practitioner's Signature	Practitioner's Health First Colorado ID	Date
______________________________	____________________	____________
Attending Practitioner Signature	Attending Practitioner Health First Colorado ID	Date

Section III: 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

Revised July 2022