Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Supplier ID or NPI #:	Date of Service:
Provider's Phone #:	Provider's Fax #:	Place of Service (City/Town)/Facility:
Provider's Contact Name:		

Clinical Information			
CPT Code:	Units:	CPT Code:	Units:

Diagnosis:	Diagnosis Code:	Gestational Age:

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	Date:

NEIGHBORHOOD DECISION ***Authorization is not a guarantee of payment.***		
Dates of Ser vice:		Services Approved:
Authorization #:	Notification Date:	❑Not Approved - Letter to Follow

UM Initials:

Neighborhood Health Plan of Rhode Island
Termination of Pregnancy Physician Certification Form
Preservation of Mother's Life

Please fax this form to Neighborhood's Utilization Management Department (401) 459-6023.

In accordance with Public Law 103-112, revision to the Hyde Amendment, the Rhode Island Department of Human Services (DHS) implemented the federal directive pertaining to Medicaid reimbursement for abortions. For dates of service on or after October 1, 1993, abortions may be performed for pregnancies resulting from rape, incest or as a result of life-threatening conditions of the mother. Reimbursement of abortions is based on the physician's "Certification Statement" below that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape or to terminate pregnancy resulting from incest.

Listed below is the physician certification statement that must accompany all claims for abortions conducted to preserve the life of the mother for federal compliance and proper reimbursement. A copy of the signed certification statement must be submitted with each claim or reimbursement to be considered. Physician signature must be original script, not typed or rubber-stamped. *Please note that substitute wording will not be acceptable.*

I, _____ *(Physician's Full Name)* certify that on behalf of my professional judgment, the procedure performed was necessary to save the life of the mother (*Recipient's Full Name and NHPRI ID#),*

_____.

Recipient Address: **_____**

Physician's Signature:_____ Date: _____