Pennsylvania Insurance Department   Children's Health Insurance Program

PHYSICIAN CERTIFICATION FOR AN ABORTION

*A COPY OF THIS FORM MUST BE ATTACHED TO **EACH** INVOICE FOR AN ABORTION SERVICE*

All information on this form will be kept strictly confidential.

Date of Service:

Patient Name:

Patient Date of Birth:

Patient's Address:

Patient's Insurance ID Number:

PLEASE COMPLETE EITHER PART I OR PART II:

Part I

☐ I certify, on the basis of my professional judgment, that this patient 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.

______________________________ ____________________

(PHYSICIAN'S SIGNATURE) (DATE)

Physician's Street Address:

Physician's Phone Number:

Part II

A MEMBER STATEMENT FORM MUST ACCOMPANY THIS DOCUMENT IF PART II IS COMPLETED.

☐ This patient is pregnant as a result of: ☐ RAPE ☐ INCEST

☐ I certify that prior to the performance of the abortion, I obtained the attached Member Statement Form signed and dated by the patient.

Complete the following only if applicable:

☐ I certify that, on the basis of my professional judgment, this patient was unable to report the incident of: ☐ RAPE ☐ INCEST and/or the identity of the offender because the patient was: ☐ Physically unable or ☐ Psychologically unable.

______________________________ ____________________

(PHYSICIAN'S SIGNATURE) (DATE)

Physician's Street Address:

Physician's Phone Number:

ATTACHMENT 2

Pennsylvania Insurance Department **Children's Health Insurance Program**

MEMBER STATEMENT FORM

*A COPY OF THIS FORM MUST BE ATTACHED TO **EACH** PHYSICIAN CERTIFICATION FOR AN ABORTION FORM THAT ATTESTS THE MEMBER WAS PREGNANT AS A RESULT OF RAPE OR INCEST*

All information on this form will be kept strictly confidential.

Patient Name:
Patient Date of Birth:
Patient's Address:
Patient's Insurance ID Number:
Type of Incident: ☐ RAPE ☐ INCEST
Date of Incident:
PLEASE COMPLETE EITHER PART I OR PART II AND THEN SIGN AND DATE BELOW
Part I: ☐ I certify that I was the victim of the above-named incident and that I reported it to the following law Enforcement or county child protective service agency: ____
Date of Report: ____________________
My Report ☐ Did ☐ Did Not Include the identity of the offender.
I ☐ Do ☐ Do Not Know the identity of the offender.
Part II: ☐ I certify that I was the victim of the above-named incident and that I did **not** report the crime.
I understand that any false statements made herein are punishable by law and that false reports to law enforcement authorities are punishable by law.
______________________________ (Signature of Victim) ____________________ (Date)