Anthem Blue Cross and Blue Shield Medicaid

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# Abortion Necessity Form

I, ____________________________________ (name of physician), certify on the basis of my

professional judgment, the pregnancy of ____________________________________ (name of patient)

of ___________________________________________________________________ (address)

___ is suffering from a physical disorder, injury or illness, including a life-endangering condition, caused by or arising from the pregnancy itself.

___ is a result of rape.

___ is a result of incest.

_______________________________________ _________________

Signature of patient Date (MM/DD/YYYY)

_______________________________________ _________________

Signature of physician Date (MM/DD/YYYY)

________________________________________________________________

Physician's address

_______________________________________

Physician's NPI

**This form must be completed in its entirety.**
**Incomplete information may result in the claim being denied.**
**Please fax form to Medical Director at 913-563-1680.**


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