State of Florida
Abortion
Certification Form

SECTION I

1. Recipient's Name:____

2. Address:____

3. Medicaid Identification Number____

SECTION II

4. On the basis of my professional judgement, I have performed an abortion on the above named recipient for the following reason:
   - ☐ The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
   - ☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
   - ☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the recipient's medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ____________________________________
Physician's Name

6. ____________________________________
Physician's Signature

7. ____________________________________
Physician's Provider Number

8. ____________________________________
Date of Signature

AHCA MedServ Form 011, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C