Select Health of South Carolina

Healthy Connections

Abortion Statement

This certification meets FFP requirements and must include all of the aforementioned criteria.

Member information

Member name _____ First Choice ID # _____ SSN _____ Date of birth _____

Member address _____ City, State ZIP _____ Phone _____

Treating provider information

Name (include credentials) _____ NPI # _____ Phone _____

Address _____ City, State ZIP _____ Fax _____

Contact person name _____ Contact email _____ Contact phone _____

Physician certification statement

I, _____, certify that it was necessary to terminate the pregnancy

of _____ for the following reason:

a. ☐ Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition:

b. ☐ The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ☐ The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

Provider signature _____ Date _____

FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Patient certification statement

I, _____, certify that my pregnancy was the result of an act of rape or incest.

Member signature _____ Date _____