

Healthy Connections 

## MEMBER INFORMATION

Member name \_\_\_\_\_ First Choice ID # \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Member address \_\_\_\_\_ City, State ZIP \_\_\_\_\_ Phone \_\_\_\_\_

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## TREATING PROVIDER INFORMATION

Name (include credentials) \_\_\_\_\_ NPI # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State ZIP \_\_\_\_\_ Fax \_\_\_\_\_

Contact person name \_\_\_\_\_ Contact email \_\_\_\_\_ Contact phone \_\_\_\_\_

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## 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 \_\_\_\_\_

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**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 \_\_\_\_\_