Reset Form

Ohio Department of Job and Family Services
ABORTION CERTIFICATION FORM

I certify that, on the basis of my professional judgment, this service was necessary because (check one box only)

☐ **1** The woman 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, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

☐ **3** The pregnancy was the result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or

☐ **4** The pregnancy was the result of an act of incest and the patient, the patient's legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or

☐ **5** The pregnancy was a result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or

☐ **6** The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

PLEASE NOTE: **The number indicators beside the empty boxes are for departmental use only.**

Patient's Name
Patient's Address
City, State, and Zip Code
Patient's Medicaid Billing Number

Physician's Name (Please Type)	
Physician's Medicaid Provider Number	
Physician's Signature	Date

OAC 5101:3-17-01 requires completion of this form in order to receive Medicaid reimbursement.

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