# CERTIFICATE OF NECESSITY FOR ABORTION (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse *only f*or abortions which meet the criteria established in Part II, Chapter 900 of the *Policies and Procedures for Physician Services* Manual.

## GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

## CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

## MEMBER INFORMATION

NAME: _____

MEDICAID #: _____

ADDRESS: _____

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## STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

☐ This patient 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 place this woman in danger of death unless an abortion is performed.

☐ Fetal Demise

☐ The pregnancy is the result of rape.

☐ The pregnancy is the result of incest.

NOTE: Please attach all supporting medical documentation.

_____, MD
(Print Name)

_____, MD
(Signature of Physician)

DMA-311 (Rev. 07/15)