



4. ☐ **MEDICALLY NECESSARY/HEALTH OF THE MOTHER ENDANGERED**
(IF CHECKED, MUST ALSO CHOOSE ONE OF THE FOLLOWING AS THE PRIMARY REASON)

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|--|--|
| ☐ Creating a serious physical or behavioral health problem for the pregnant mother. | ☐ Exacerbating a health problem of the pregnant mother. |
| ☐ Seriously impairing a bodily function of the pregnant mother. | ☐ Preventing the pregnant mother from obtaining treatment for a health problem. |
| ☐ Causing dysfunction of a bodily organ or part of the pregnant mother. | |

COMPLETE ONLY WITH THE USE OF MEDICATIONS

_____ NAME OF MEDICATION(S) (IF APPLICABLE)	_____ DATE GIVEN
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CONFIRMATION OF TERMINATION AND DURATION OF PREGNANCY (REQUIRED)

Duration of Pregnancy: _____ Days.

☐ **DOCUMENTATION OF CONFIRMED TERMINATION IS ATTACHED**

_____ PHYSICIAN SIGNATURE	_____ DATE	
_____ PHYSICIAN PRINTED NAME	_____ PHYSICIAN PHONE	_____ FAX
_____ PRIOR AUTHORIZATION NUMBER	_____ DATE	

FOR CONTRACTOR AND AHCCCS (FOR FEE-FOR-SERVICE (FFS) MEMBERS) USE ONLY

☐ **APPROVED**

☐ **DENIED**

DENIAL REASON (IF APPLICABLE)

DATE (OF APPROVAL/DENIAL)

*CONTRACTOR MEDICAL DIRECTOR
(OR AHCCCS MEDICAL DIRECTOR SIGNATURE FOR FFS MEMBERS)*