

CONTRACTOR NAME AND LINE OF BUSINESS: _____

REPORTING DATE: _____

NAME OF INDIVIDUAL COMPLETING FORM: _____
NAME TITLE

When terminations have been authorized by the Contractor, the following information shall be provided:

AHCCCS MEMBER ID	*REASON	**AGE	RATE CODE	PROCEDURE CODE	DATE OF SERVICE

CHOOSE ONE OF THE FOLLOWING CODES:

***Reasons for Termination**

- A. Life of mother endangered
- B. Result of Incest
- C. Result of Rape
- D. Medically Necessary

****Age/Condition**

- a) Under 18 years of age
- b) Incapacitated, over 18 years of age
- c) 18 years of age and older

FOR EACH AUTHORIZED PREGNANCY TERMINATION, ATTACH TO THIS REPORT THE FOLLOWING:

1. A copy of the written consent.
2. A copy of the Prior Authorization (PA) request.
3. A copy of the AHCCCS Certificate of Necessity for Pregnancy Termination form.
4. A copy of the Verification of Diagnosis by Contractor for Pregnancy Termination request.
5. A copy of the official incident report, when rape or incest is involved unless the treating physician certifies, in their professional opinion, that the member was unable for physical or psychological reasons to comply with the requirements to report the rape and/or incest to the authorities
6. Clinical documentation demonstrating that the pregnancy termination occurred.
7. Clinical reports and medical documentation supporting justification for pregnancy termination.

REPORTS AND SUPPORTING DOCUMENTATION SHALL BE SUBMITTED AS SPECIFIED IN CONTRACT.
ANY ADDITIONAL INFORMATION DISCOVERED AFTER SUBMISSION MUST BE SUBMITTED TO AHCCCS
UPON RECEIPT FOR REVIEW AND CONSIDERATION.