CareFirst Community Health Plan District of Columbia

PHYSICIAN CERFTIFICATION FOR ABORTION

COPY MUST BE ATTACHED TO ALL ABORTION SERVICES REQUESTS

Medicaid Number	Date
Name	Date of Birth

Address _____
Street Address

_____ _____ _____
City State Zip Code

COMPLETE EITHER PART I OR PART II

PART I : LIFE THREATENING

Based on my professional judgement, I certify the patient condition, illness or injury will most likely result in death unless an abortion is performed.

_____ _____
Physician PRINT Physician Signature

_____
Street Address

_____ _____ _____ _____ _____
Date Phone Number City State Zip Code

PART II: RAPE OR INCEST

The patient is the alleged victim of rape or incest

_____ _____
Physician Signature Street Address

_____ _____ _____ _____ _____
Date Phone Number City State Zip Code