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* for abortion 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 _____

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.**
- ☐ **The pregnancy is the result of rape.**
- ☐ **The pregnancy is the result of incest.**

_____, M.D.
(Print Name)

_____, M.D.
(Signature of Physician)