



TennCare, a Division of Health Care Finance and Administration

Rev. April 24, 2015

CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

DATE OF SERVICE: _____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Individual's Full Name: _____

Individual's Date of Birth: _____

Individual's Address: _____
Street Address City State Zip Code

for the following reason:

(CHECK ONE)

- There is credible evidence to believe the pregnancy is the result of rape or incest.
- The abortion is medically necessary as the woman 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 the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION:

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

- Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.
- Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.
- Medical records documenting the lifesaving nature of the abortion.
- Other (Please Specify): _____

PHYSICIAN PERFORMING ABORTION:

Physician NPI#: _____

Physician Address: _____

Physician Signature: _____ Date: _____