Nevada Medicaid and Check Up

Certification Statement for Abortion to Save the Life of the Mother

This form must be attached to all claims for payment. Please print.

SECTION I (Recipient Information)	
Recipient's Name:	
Recipient's Address:	
Recipient's Medicaid ID:	Recipient's Date of Birth:
Date Services Rendered:	Gestational age of unborn:
Medical Records Attached: ☐ Yes ☐ No	
SECTION II (Provider Information)	
Provider's Name:	
Provider's Address:	
Provider's Phone Number:	Provider's National Provider Identifier:
Medical condition necessitating induced abortion. Please include ICD-10 Diagnosis Code(s):	
Description of services and procedure code(s) billed:	
Name of facility where services were provided:	
The life of the mother would be endangered if the fetus were carried to term: ☐ Yes ☐ No	
Provider Signature:	Date:
NOTE: The provider performing the abortion is responsible for sending the required documentation to other providers (i.e. facility, anesthesia provider, etc.) for billing purposes. In addition, the facility may choose to obtain their own certification for their billing purposes.	