

# Certificate to Request Federal (Medicaid) or State (General) Funds for Abortion

The Hyde Amendment allows federal funds to be expended for an abortion only “(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a 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, as certified by a physician, place the woman in danger of death unless an abortion is performed.”

In accordance with a 2001 order of The Supreme Court of the State of Alaska, the Alaska Medicaid program must, under certain circumstances, provide funding for abortions for women who receive Alaska Medicaid but for whom the abortion is not covered by Medicaid. If the abortion was not elective and was necessitated because the pregnancy endangered the health of the woman, the Alaska Medicaid program may pay some or all of the costs.

\_\_\_\_\_  
(Recipient's Full Name)

\_\_\_\_\_  
(Recipient's Medicaid Identification Number)

had an abortion procedure performed on \_\_\_\_/\_\_\_\_/\_\_\_\_ (month /day/ year).

### Federal Medicaid Funding (must select one of the following)

I certify that prior to performing the abortion procedure on the above patient I obtained a non-notarized signed statement from the patient that her pregnancy was the result of an act of (select one)  rape or  incest. That statement is now part of the patient's medical record;

**OR**

I certify that in my professional judgment, the abortion procedure on the above patient was performed due to 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 was performed, based on full consideration of all factors as described in the attached operative report;

**OR**

I certify that neither of the above applies. If this box is checked, one of the following must be selected:

### State General Funding (available only if federal funding criteria are not met)

I certify that the abortion performed was not an elective procedure and I certify that in my professional judgment, the abortion was performed due to the health of the woman being endangered by the pregnancy;

**OR**

I certify that the above statement does not apply. This procedure is not eligible for reimbursement.

This certificate must be signed and dated by the recipient's attending physician and must be submitted to the Division of Health Care Services at the address below. A facsimile signature or signature of the physician's authorized representative is not acceptable. No payment will be made for an abortion or abortion-related service without a signed certificate on file.

\_\_\_\_\_  
Signature of Recipient's Attending Physician

M.D. or D.O.

\_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)  
Date of Physician's Signature

**Submit the original completed and signed certificate to:**

**Alaska Division of Health Care Services  
Attention: Medical Review  
4501 Business Park Blvd., Bldg. L Suite 24  
Anchorage, AK 99503-7167**