APPLICATION FOR VIRGINIA DEPARTMENT OF HEALTH STATE FUNDED ABORTION UNDER SECTIONS 32.1-92.1 and 32.1-92.2 of CODE OF VIRGINIA, AS AMENDED

FAX APPLICATION TO: (804) 864-7771

Section 1: Patient Applicant Information

To be completed by Certifying Physician/Abortion Facility

Date of Application: ________________________

Name of Patient Applicant:_________________________

Date of Birth:______________________________

Address:____

Medicaid Number:_________________________

____

Date of Procedure:________________________

City/County of Residence: ___________________________

Name of Abortion Facility: ____

Name of Certifying Physician:____

Section 2: Medical Information and Certification

All Certifying Physicians must complete section 2A

Certifying Physicians must choose and complete either 2B or 2C

All Certifying Physicians must print name, sign and date

Required Certification

2A: I certify that my examination of the patient applicant and/or her medical record indicates that she is _______ weeks pregnant as of________________ (date)

Section 32.1-92.1: Cases of Rape or Incest

2B: I hereby request state funds under the provisions of § 32.1-92.1 of the **Code of Virginia**, as amended. This pregnancy is the direct result of either rape or incest. The patient has verified that this event has been reported to a law enforcement or public health agency.

Date of Occurrence: ________________________

Date Reported:_____________________________

Reported to: ____

Section 32.1-92.2: Cases of gross and totally incapacitating physical and/or mental deformity

2C: I hereby request state funds under the provisions of § 32.1-92.2 of the **Code of Virginia**, as amended.
Attach all diagnostic procedure results:

☐ Amniocentesis ☐ Ultrasound ☐ Blood Test ☐ Other

Summary of diagnostic procedure results:

____

____

____

I certify that my examination of the patient applicant and review of diagnostic tests indicate that the fetus will be born with a gross and totally incapacitating physical deformity and/or a gross and totally incapacitating mental deformity.

Required Signature

Certifying physician (Print name): ____

Certifying physician (Signature): _________________________________ Date: ________________________

Section 3: Verification

Certifying physician license #: _______________ License expiration date:__________________________

Section 4: VDH Physician Review

☐ Approved ☐ Not Approved

Rationale:____

____

____

Primary Physician Reviewer: ____________________Date:_______________

☐ Approved ☐ Not Approved

Rationale:____

____

____

Secondary Physician Reviewer:___________________________Date:______________________

Section 5: Acknowledgement

Acknowledgement: "The Virginia Department of Health guarantees payment to the facility named in the application for performing an abortion on the individual named herein as the 'Patient Applicant'. Such payment shall be limited to the usual reimbursement rate established by the Virginia Medical Assistance Program (Medicaid), and shall constitute "full and final payment for such services." VDH reserves the right to deny payment if there is violation of the Code of Virginia.

OFHS Administration:____ Date: __________________________

1. **Fax this application to: (804) 864-7771**
2. **Submit bills on CMS 1500 to:**
   Reproductive Health Unit
   Virginia Department of Health
   P.O. Box 2448
   109 Governor St.
   Richmond, VA 23219
3. **Provide approved copy of this application to the patient applicant**
4. **Provide the abortion facility a signed copy for billing purposes**