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 UPLOAD APPLICATION HERE:
https://redcap.vdh.virginia.gov/redcap/surveys/?s=3J7X7P3443

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. **Upload this application here: https://redcap.vdh.virginia.gov/redcap/surveys/?s=3J7X7P3443 or Fax this application to: (804)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**