

**APPLICATION FOR VIRGINIA DEPARTMENT OF HEALTH STATE FUNDED ABORTION
 UNDER SECTIONS 32.1-92.1 and 32.1-92.2 of CODE OF VIRGINIA (1950), AS AMENDED
 FAX APPLICATION TO: (804) 864-7771**

**Section 1: Patient Applicant Information
 To be completed by Certifying Physician or Abortion Facility**

Date of Application: _____ Name of Patient Applicant: _____
 Date of Birth: _____ Address: _____
 Medicaid Number: _____
 Date of Procedure: _____ City/County of Residence: _____
 Name and type of Facility: _____ Abortion Hospital
 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**

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** (1950) 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** (1950) 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.

Print name: _____
 Certifying physician: _____ Date: _____

Section 3: Verification

Certifying physician license #: _____ License expiration date: _____

Facility license #: _____ Approved to provide abortions: _____ YES _____ NO

Section 4: VDH Physician Review

Approved Not Approved

Rationale: _____

OFHS Deputy Director, or designee, 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: _____

1. **Fax this application to: (804) 864-7771**
2. **Submit bills on CMS 1500 to:**
Family Planning Supervisor
Division of Child and Family Health
Office of Family Health Services
Virginia Department of Health
P.O. Box 2448, 8th Floor
Richmond, VA 23218
3. **Provide approved copy of this application to the patient applicant**
4. **Provide the abortion facility a signed copy for billing purposes**