Maryland
DEPARTMENT OF HEALTH

Maryland Medical Assistance Program
Certificate for Abortion (MDH 521)

The Certification for Abortion (MDH 521) form must be completed by the qualified provider performing the procedure and kept in the patient's Medical Record.*

Part I. Demographics

Patient Name:_____ Patient Medicaid #: _____

Patient Address: _____

Provider Name:_____ Date of Service: _____

Provider NPI #:_____ Place of Service:_____

Part II. Please choose from <u>one</u> of the following certifying criteria: 1, 2 or 3.

1. **Abortion was necessary because of the potential endangerment to the health of the patient/woman (For this criteria choose which description <u>best describes</u> the medical certification - A, B or C).**

❑ A. I certify that this abortion is necessary because, based on my professional judgement, continuation of the pregnancy is likely to result in death of the woman.

Date:_____ Provider's signature:_____

❑ B. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, termination of pregnancy is medically necessary because there is substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical (somatic) health.

Date:_____ Provider's signature:_____

❑ C. I certify that, in my professional judgement, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health.

Date:_____Provider's signature:_____

2. **Abortion was necessary because of serious genetic defects, deformities, or abnormalities to the fetus.**

   ❑ I certify that, within a reasonable degree of medical certainty, based on my professional judgement, this abortion is necessary because the fetus is affected by a genetic defect or serious deformity or abnormality.

   Date:_____Provider's signature:_____

3. **Abortion was neccessary for a woman where the pregnancy was reported as a result of rape or incest. (<u>Complete both boxes A & B</u>)**

   ❑ A. I certify that this procedure is necessary for a victim of rape, sexual offense, or incest, and the incident has been reported to a law enforcement agency or to a public health or social agency.

   Date:_____Provider's signature:_____

   ❑ B. Attached is a document submitted by an official of a law enforcement agency or public health service where the rape or incest was reported. The document includes the following information:
   1. Name and address of victim;
   2. Name and address of person making the report (if different from the victim);
   3. Date of the rape or incest incident;
   4. Date of the report (may not exceed 60 days after the incident);
   5. Statement that the report was signed by the person making it; and
   6. Name and signature of person at law enforcement agency or public health service who took the rape or incest report.

   Date:_____Provider's signature:_____

*Providers must complete t**he Certification for Abortion (MDH-521) form and keep it in the patient's medical record. Providers must make the MDH 521 form available upon request.** Providers are **<u>not</u>** required to submit the MDH 521 with the claim. Instead, providers must indicate the appropriate two-character alpha condition code in Block 10d of the claim form. For complete information regarding billing codes and procedures, please refer to the CMS-1500 Billing Instructions at health.maryland.gov/providerinfo.