MISSISSIPPI MEDICAID
ABORTION NECESSITY FORM

Beneficiary Name: _____ MS Medicaid ID #: _____
(Please Print)

CERTIFICATION REQUIRED:

I, _____ (name of physician),

certify that on the basis of my professional judgment that this procedure should be performed on _____ (name of patient), of

_____ (address) because:

1. ____ necessary to save the life of the mother.

2. ____ pregnancy is result of alleged rape.

3. ____ pregnancy is result of alleged incest.

Date of Procedure: _____

_____
(Signature of Physician)

MA-1034
Revised 03/06