CHORUS
COMMUNITY HEALTH PLANS

Abortion Attestation Form

Chorus Community Health Plans requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.
Members of Chorus Community Health Plans are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS104.02[4], Wis. Admin. Code).

Coverage Policy
In accordance with s. 20.927, Wis. Stats., abortions are covered when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests that sexual assault or incest has occurred, to his or her belief, by signing a written certification; the crime must also be reported to the law enforcement authorities.

Instructions
The use of this form is required when filing a claim for reimbursement of an abortion with Chorus Community Health Plans. Physicians are required to attach or upload a completed and signed certification statement attesting to one of the previous circumstances when filing the claim.

SECTION 1: Life of the Woman

I, _____, certify on the basis of my best clinical judgment, abortion is
(Provider's Name)
directly and medically necessary to save the life of:
_____, of _____
(Member's Name) (Member's Address)

For the following reasons:
_____
_____
_____

(Physician's signature) (Date Signed)

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SECTION 2: Victim of Sexual Assault or Incest

I,_____, certify that it is the belief that
(Provider's Name)

_____, of
(Member's Name)

_____, was the victim of
(Member's Address)

sexual assault or incest.

_____
(Physician's signature) (Date Signed)