



Operations Bulletin 01-10

Date: March 8, 2010
To: Participating Providers
Subject: CHIP Abortion Services

Geisinger Health Plan would like to clarify the existing certification requirements for abortion services provided to Children's Health Insurance Program (CHIP) members. Beginning February 1, 2010, a completed copy of the CHIP Physician Certification Abortion Form (Attachment A) must accompany all claims for abortion services. Also, if applicable, a copy of the Member Statement Form (Attachment B), must accompany claims for abortion services in order for the services to be evaluated for proper coverage. Abortion services are covered by Geisinger Health Plan's CHIP product only under one of the below conditions:

1. The physician certifies, through completion of Part I of the Physician Certification Abortion Form, that the Member/mother suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. Or;
2. The physician certifies, through completion of Part II of the Physician Certification Abortion Form, that the Member/mother is pregnant as a result of an act of rape or incest. The provider must ask the Member if she reported the incident to law enforcement authorities or child protective services. If she has not reported the incident and the physician certifies that she was physically or psychologically unable to do so, the requirement to report the incident of rape or incest must be waived. ***If the physician completes Part II of the Physician Certification Abortion Form, the physician must obtain a completed Member Statement Form from the patient and submit both documents in order for the abortion service to be evaluated for coverage by Geisinger Health Plan's CHIP product.***

Completed Physician Certification Abortion Forms and Member Statement Forms may be faxed to Geisinger Health Plan's Customer Service Team at (570) 271-5871 or the forms may accompany the claim form.

Geisinger Health Plan's CHIP Member ID cards do not display the CHIP logo and are almost identical to Geisinger Health Plan's standard HMO ID cards. Member eligibility can be verified by calling the dedicated CHIP customer service phone number on the back of the ID card [(570) 214-9138; (866) 621-5235].

This Operations Bulletin amends the Participating Provider Guide Dev 10/08. Geisinger Health Plan will make the Physician Certification Abortion Form and Member Statement Form available in the forms section of the Participating Provider Guide online at www.thehealthplan.com. If you have any questions or would like more information, please contact your Provider Relations Representative at the applicable telephone number listed below:

Danville: (800) 876-5357
(570) 271-5140

Scranton: (800) 350-6486
(570) 341-1754

Harrisburg: (888) 281-5338
(717) 909-3340

State College: (888) 669-4834
(814) 238-0028

Pennsylvania Insurance Department

Children's Health Insurance Program

PHYSICIAN CERTIFICATION FOR AN ABORTION*A COPY OF THIS FORM MUST BE ATTACHED TO EACH INVOICE FOR AN ABORTION SERVICE**All information on this form will be kept strictly confidential.*

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|---|
| Date of Service: |
| Patient Name: |
| Patient Date of Birth: |
| Patient's Address: |
| Patient's Insurance ID Number: |
| PLEASE COMPLETE EITHER PART I OR PART II: |
| <u>Part I</u> |
| <input type="checkbox"/> I certify, on the basis of my professional judgment, that this patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. |
| <hr style="width: 50%; display: inline-block; vertical-align: middle;"/> <hr style="width: 50%; display: inline-block; vertical-align: middle;"/> (PHYSICIAN'S SIGNATURE) (DATE) |
| Physician's Street Address: |
| Physician's Phone Number: |
| <u>Part II</u> |
| A MEMBER STATEMENT FORM MUST ACCOMPANY THIS DOCUMENT IF PART II IS COMPLETED. |
| <input type="checkbox"/> This patient is pregnant as a result of: <input type="checkbox"/> RAPE <input type="checkbox"/> INCEST |
| <input type="checkbox"/> I certify that prior to the performance of the abortion, I obtained the attached Member Statement Form signed and dated by the patient. |
| <i>Complete the following only if applicable:</i> |
| <input type="checkbox"/> I certify that, on the basis of my professional judgment, this patient was unable to report the incident of: <input type="checkbox"/> RAPE <input type="checkbox"/> INCEST and/or the identity of the offender because the patient was: <input type="checkbox"/> Physically unable or <input type="checkbox"/> Psychologically unable. |
| <hr style="width: 50%; display: inline-block; vertical-align: middle;"/> <hr style="width: 50%; display: inline-block; vertical-align: middle;"/> (PHYSICIAN'S SIGNATURE) (DATE) |
| Physician's Street Address: |
| Physician's Phone Number: |

Pennsylvania Insurance Department Children's Health Insurance Program

MEMBER STATEMENT FORM

A COPY OF THIS FORM MUST BE ATTACHED TO EACH PHYSICIAN CERTIFICATION FOR AN ABORTION FORM THAT ATTESTS THE MEMBER WAS PREGNANT AS A RESULT OF RAPE OR INCEST

All information on this form will be kept strictly confidential.

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| Patient Name: |
| Patient Date of Birth: |
| Patient's Address: |
| Patient's Insurance ID Number: |
| Type of Incident: <input type="checkbox"/> RAPE <input type="checkbox"/> INCEST |
| Date of Incident: |
| PLEASE COMPLETE EITHER PART I OR PART II AND THEN SIGN AND DATE BELOW |
| Part I: |
| <input type="checkbox"/> I certify that I was the victim of the above-named incident and that I reported it to the following law Enforcement or county child protective service agency: _____ |
| Date of Report: _____ |
| My Report <input type="checkbox"/> Did <input type="checkbox"/> Did Not Include the identity of the offender. |
| I <input type="checkbox"/> Do <input type="checkbox"/> Do Not Know the identity of the offender. |
| Part II: |
| <input type="checkbox"/> I certify that I was the victim of the above-named incident and that I did not report the crime. |
| I understand that any false statements made herein are punishable by law and that false reports to law enforcement authorities are punishable by law. |
| _____ (Signature of Victim) |
| _____ (Date) |