

**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