

Prior Approval #: _____

Date Approved: _____ By: _____

State of North Carolina
Division of Social Services
State Abortion Fund Authorization

1. _____ the "Primary Provider" is authorized by _____, of the _____ (Worker) _____ County Department of Social Services, the "Department," to provide an abortion under the State Abortion Fund for: _____ SIS ID# _____

2. The Division of Social Services will process claims and directly reimburse providers through the State Abortion Fund based on all-inclusive maximum rates as related to length of gestation and place of service. (See reverse side for rate structure.) Reimbursements will be made only for abortions when the length of gestation, as determined by the attending physician is one hundred and forty (140) days or 20 weeks or less and the procedures are performed in accordance with State laws. The authorized amount \$ _____ is based upon the recipient's statement of gestation, which is approximately _____ weeks.

3. Does the recipient have health insurance that includes coverage for all or part of the bill for elective abortion services? Yes No **If yes, the providers must file for benefits with the insurance company prior to requesting reimbursement from the Division of Social Services and must deduct the insurance payment from their designated share of the maximum reimbursement.**

4. The primary provider is hereby authorized to arrange for, and negotiate the payment for any additional medical services needed in conjunction with the provision of the abortion so long as the total claims do not exceed the applicable established maximum reimbursement rate. FEES MAY NOT BE COLLECTED FROM THE RECIPIENT BY ANY PROVIDER PARTICIPATING IN THE SERVICE AUTHORIZED BY THIS AGREEMENT.

5. The authorized amount in paragraph 2 will be divided among the providers indicated below: **TO BE COMPLETED BY PRIMARY PROVIDER**

Name of Provider	Service Provided	Amount to be Reimbursed
a. _____	<u>Surgical Procedure</u>	_____
b. _____	<u>Hospital or Clinic Services</u>	_____
c. _____	<u>Anesthesia, if separate</u>	_____
d. _____	<u>Other:</u>	_____

(Use back of form if needed)

Total (not to exceed the authorized amount in paragraph 2): \$ _____

6. (a) The primary provider will (1) sign the authorization, (2) **SUPPLY EACH ADDITIONAL PROVIDER, IF ANY, WITH A COPY OF THE COMPLETED AUTHORIZATION**, and (3) return a copy of the Authorization to the County Department with his/her claim. The additional providers will return their copy of the Authorization to the Department with their individual claims for authorized services delivered;

(b) The Department will verify that the fee for services was authorized and does not exceed the maximum flat rate for the gestational period. Following verification the Department will forward the authorization and claim to:

**N.C. Division of Social Services
Attention: Family Support and Child Welfare Services - SAF
2409 MSC
Raleigh, North Carolina 27699-2409**

CLAIMS MUST BE SUBMITTED TO THE COUNTY DEPARTMENT OF SOCIAL SERVICES FOR PAYMENT WITHIN TWO (2) MONTHS OF THE DATE OF SERVICE.

THE PRIMARY PROVIDER AND PROVIDERS OF ADDITIONAL MEDICAL SERVICES WILL KEEP CONFIDENTIAL ANY INFORMATION ABOUT THE RECIPIENT WHICH IS SHARED BY THE DEPARTMENT OR THE RECIPIENT. SUCH INFORMATION SHALL BE SHARED ONLY AMONG THE DEPARTMENT, PRIMARY PROVIDER, AND PROVIDERS OF ADDITIONAL MEDICAL SERVICES WHO NEED TO KNOW IN ORDER TO COORDINATE, MANAGE OR DELIVER SERVICES TO THE RECIPIENT.

Department
Signature: _____

Primary Provider
Signature: _____

Title: _____

Title: _____

Date of Authorization: _____

Date: _____

1. **Purpose**

This form is to be used to purchase an abortion under the State Abortion Fund, and to authorize reimbursement for services delivered to a specific individual by a designated provider(s). A separate authorization must be negotiated for each individual recipient who is authorized to receive the service. Services are provided in accordance with the policies, procedures, and standards contained in Volume I, Chapter XII, of the Division of Social Services' Family Support and Child Welfare Services manual.

2. **General Information**

Complete and sign three copies of the form. The original of the DSS-6847 only should be sent to the primary provider, one copy together with the DSS-6211 and DSS-6212 should be sent to the Division of Social Services, Attention: Family Support and Child Welfare Services - SAF, 2409 MSC, Raleigh, North Carolina 27699-2409, and the final copy should be retained in the recipient's service record with a copy of the DSS-6211, the DSS-6212 and any other required supporting documentation about the abortion. The primary provider will be responsible for supplying a copy of the authorization to any necessary provider(s) of related medical services.

3. **Instruction for Completing the Form**

- Paragraph 1: Enter the name of the county, the name of the primary provider (attending physician), and the name and SIS ID Number of the individual who is to receive the service.
- Paragraph 2: Enter the authorized amount within the allowable flat rate which will be paid for all medical procedures related to the abortion. (See rate structure below) Enter the estimated length of gestation.
- Paragraph 3: The social worker completing the authorization should indicate with a check (✓) whether the recipient has health insurance that includes coverage for all or part of the bill.
- Paragraph 4: Review thoroughly.
- Paragraph 5: List the names of any additional providers of medical services which have been determined to be necessary and for which the maximum reimbursement amount entered in paragraph 2 of this authorization will be shared. Enter the amount that each provider is to be reimbursed beside the name. (Note paragraph 3) The total amount including reimbursement to the primary provider may not exceed the maximum reimbursement rate for the gestational period and place of service.
- Paragraph 6: Review thoroughly.

4. **Instruction for the Primary Provider and Providers of Additional Medical Services.**

- a. Prior to service delivery, thoroughly review this entire authorization, especially the statement regarding confidentiality.
- b. The primary provider is to notify the authorizing county department of social services if the diagnosed gestational period differs from the estimated period to the extent that it affects the authorized reimbursement of service. This is necessary in order to maintain accurate records and to establish an appropriate encumbrance.
- c. The primary provider must complete Paragraph 5.
- d. The primary provider must sign and date this authorization.
- e. The primary provider must send a copy of the signed authorization to each provider listed in Paragraph 5 and instruct each to attach it to his/her billing statement.
- f. Each provider shall return the completed authorization to the county department of social services, attached to the provider's billing statement, as soon as possible following completion of the service. Claims must be submitted within two (2) months of the date of service.

ALL-INCLUSIVE MAXIMUM REIMBURSEMENT RATES*

Length of Gestation	Place of Service	Maximum Rate
1 to 12 weeks (1 to 84 days)	Any certified facility; abortion clinic; out-patient hospital; in-patient hospital; or ambulatory facility	\$225.00
13 to 14 weeks (85 to 98 days)	Abortion clinic; ambulatory surgical facility; out-patient hospital clinic	\$336.00
15 to 20 weeks (99 to 140 days)	Abortion clinic; ambulatory surgical facility; out-patient hospital clinic	\$382.00
13 to 20 weeks (85 to 140 days)	Hospital in-patient (;payment split with all medical providers)	\$500.00

*These all-inclusive maximum reimbursement rates include a post abortion visit and Rhogan, if needed.