Illinois Department of Healthcare and Family Services

Abortion Payment Application

Recipient Name _____

Recipient Address _____

Case Identification No. _____ Recipient Identification No. _____

I performed an abortion for the patient named above at

_____ on _____ .

Location (Name, City) Date

The abortion was performed because:	(Check one code only) Surgical	Mifepristone
The abortion was necessary due to a physical disorder, injury or 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.	☐	☐
The recipient reported that the pregnancy was the result of rape.	☐	☐
The recipient reported that the pregnancy was the result of incest.	☐	☐
The abortion was necessary to protect the woman's health.	☐	☐

I understand that completion of this form is for Medical Assistance payment purposes only.

_____ _____

Physician performing abortion (Please Print) Medicaid Provider Number

_____

Street Address

_____ _____ _____

City State Zip

_____ _____

Signature of physician performing abortion Date

Completion mandatory, 305ILCS 5/1-1 et. seq. Penalty non-payment.
Form approved by the Forms Management Center.

COMPLETION OF FORM HFS 2390
ABORTION PAYMENT APPLICATION

Note: If any of the following items are not completed as outlined below, the invoice and the Payment Application Form will be returned to the provider. Entries must be typed or printed in black ink.

ITEM	INSTRUCTIONS
Recipient Names	Must be recipient's first and last name.
Recipient's Address	Must be completed with recipient's address.
Recipient's Case Identification Number	Must be completed with recipient's case identification number.
Recipient I.D. Number	Must be completed with the receipient's I.D. number. Must match recipient's I.D. number on invoice.
Location	Must be the facility name and address where the procedure was performed. If procedure was performed in an office setting, enter name and address of the physician or clinic.
Date	Must be the date service was performed.
Abortion Reason	Circle on procedure code only indicating why and how the procedure was performed. Must match procedure code on the invoice.
Physician Performing Abortion	Print the physician's full name.
Medicaid Provider	Enter the provider's medicaid number or state license number.
Street Address	Enter the provider's office street address.
City, State, Zip	Enter the provider's office city, state and zip code.
Signature of Physician Performing Abortion	This is an original signature in black ink of the physician who performed the abortion.
Date	Enter the date the physician signed the application.