HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Beneficiary Full Name: ______________________ Sponsor's SSN: ______-_____-_______

Date of Birth: ______________________ Beneficiary State of Residence: ______________

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter or attach it to your **online request**.

Coverage is limited to one bariatric surgery cost-shared by TRICARE per lifetime except for specific conditions outlined in the TRICARE Policy Manual, Chapter 4, Section 13.2. **This form should not be used if the beneficiary has had a previous bariatric surgical procedure.** If questions one, two and three below are not met, the beneficiary does not meet the requirements for bariatric surgery and you may receive a denial letter.

Beneficiary height: ______________

Beneficiary weight: ______________

Beneficiary body mass index (BMI): ______________

1. Does the patient have a body mass index greater than or equal to 40 kg/m2?

   ☐ Yes ☐ No

   OR

   Does the patient have a body mass index of 35–39.9 kg/m2 with one clinically significant co-morbidity?

   ☐ Yes ☐ No

   If yes, check the applicable boxes below:

☐ **Type II diabetes mellitus** based on medications (e.g., insulin, metformin, glyburide or glipizide) and diagnosed by a primary care provider, internist or endocrinologist.

☐ **Hypertension** with blood pressure (BP) documented as greater than 140/90 or documented use of BP medications with a diagnosis of hypertension (HTN).

☐ **Pickwickian syndrome/OSAS** with abnormal sleep study, documentation of continuous positive airway pressure (CPAP) use for obstructive sleep apnea (OSA) and diagnosis by a pulmonologist or sleep specialist (snoring or fatigue alone does not count).

☐ **Cardiovascular disease**

☐ **Hypothalamic disorder**

☐ **Severe arthritis of weight bearing joints** with radiographic evidence of osteoarthritis of weight bearing joints. (Joint pain alone does not count.)

☐ **Coronary artery disease**, such as a history of myocardial infarction (MI), angina, cardiac bypass/stent, congestive heart failure, abnormal cardiac catheterization or other:

____

☐ **Pulmonary hypertension**

☐ **Obesity related cardiomyopathy**

☐ **Pseudotumor cerebri**

☐ **Non-alcoholic fatty liver disease (NAFLD)**

☐ **Gastroesophageal reflux disease (GERD)**

☐ **Dyslipidemia**

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L.104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved. • HF0917x094 (01/22)

HEALTH NET FEDERAL SERVICES | TRICARE

2. Has the patient completed growth (18 years of age or documentation of completion of bone growth)?
☐ Yes ☐ No

3. Has the patient been previously unsuccessful at nonsurgical medical treatment for obesity as documented in the beneficiary s record with at least monthly clinical encounters with the physician? Physician supervised programs consisting exclusively of pharmacological management are not sufficient to meet his requirement.
☐ Yes ☐ No

If the patient has TRICARE Select coverage STOP here.

Physicians: Please be sure to sign and date the attestation at the bottom of this document. No further information is required for TRICARE Select patients.

If the patient has TRICARE Prime coverage, the remaining questions must be answered for HNFS to make a coverage determination.

4. Has the patient had an adequate pre-op evaluation? Check the services that have been completed.
☐ Cardiac/pulmonary evaluation ☐ Dietary consult ☐ Psych consult ☐ Endocrinopathy excluded.
If not indicated, please explain: ______________________________

5. Does patient have evidence of gastrointestinal symptoms, peptic ulcer disease or gastritis? ☐ Yes ☐ No
If yes, has peptic ulcer disease been ruled out or treated? Check the applicable box below:
☐ Negative H. pylori (If the H. pylori test is positive but treatment is documented, consider the H. pylori negative.)
☐ Esophagogastroduodenoscopy (EGD)
☐ Upper gastrointestinal (UGI)

6. Is there a history of drug or alcohol abuse? ☐ Yes ☐ No
If yes, has the patient been alcohol or drug free for greater than one year? ☐ Yes ☐ No

7. Has the patient been smoke-free greater than six weeks or has no history of smoking? ☐ Yes ☐ No

8. Is there a mental health disorder (for example, severe psychosis, personality disorder or anxiety disorder)?
☐ Yes ☐ No
If yes, answer both questions below:
a. Is the condition being treated? ☐ Yes ☐ No
b. Does the mental health consultant agree with the recommended surgery? ☐ Yes ☐ No

9. Does the patient understand the surgical risk, post-procedure complications and follow-up? ☐ Yes ☐ No

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: ______________________________

Physician's Printed Name and Title: ______________________________

TIN: ______________________________

Physician's Signature: ______________________________ Date: ______________