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.

TRICARE Policy Manual, Chapter 4, Section 5.2 authorizes coverage of external breast prosthesis in lieu of reconstructive breast surgery. Breast prostheses are limited to the first initial device per missing body part. Requests for replacement are subject to medical review.

TRICARE Policy Manual, Chapter 8, Section 4.1 authorizes coverage of replacement prosthetics when required due to growth or a change in the patient's condition, or when the device is lost, irreparably damaged or the cost of repair would exceed 60 percent of the cost of replacement. Explicitly excluded from coverage are duplicate or similar prosthetics (unless the beneficiary requires bilateral prostheses), prosthetic devices intended for sports related purposes, personal comfort, or convenience.

In order for a breast prosthesis replacement to be covered, the provider must attest one of the following statements is true:

- ☐ The beneficiary's existing breast prosthesis is worn out, not serviceable or irreparably damaged.
- ☐ The beneficiary's existing breast prosthesis is damaged and the cost of repair would exceed 60 percent of the cost of replacement.
- ☐ The beneficiary's existing breast prosthesis has been lost.
- ☐ A replacement prosthesis is necessary due to a change in the patient's condition.

  Please describe: _____

The following indications are unlikely to meet coverage criteria:

- ☐ A duplicate or similar prosthesis is requested. The beneficiary's existing prosthesis remains serviceable and appropriate for the beneficiary.
- ☐ A second prosthesis is requested for sports related purposes (for example, aquatic breast prosthesis).
- ☐ A second prosthesis is requested for personal convenience (for example, a different size to be worn with particular items of clothing).
- ☐ A second prosthesis is requested for personal comfort. Please describe: _____

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: _____

Signature: _____ Date: _____

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