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.

Circumcision is a limited benefit under TRICARE. TRICARE Policy Manual, Chapter 7, Section 2.5 authorizes male circumcision performed during the newborn period (0-30 days). Male circumcision performed outside the newborn period due to medical complications at birth or during the newborn period that prevented performing the circumcision within the newborn period may be covered up to 30 days after discharge. Male circumcision performed after the newborn period without medical complications at birth may be covered if medically necessary and otherwise authorized for benefits.

Please note: TRICARE policy excludes coverage of procedures that are not medically necessary for the diagnosis or treatment of a covered illness.

In order for circumcision to be covered, the provider must attest one of the following statements is true:

☐ This infant/child requires circumcision outside the newborn period because of medical complications at birth or during the newborn period (0-30 days after birth) that prevented performance of the cir cumcision during the newborn period (for example, premature delivery requirement NICU care). The circumcision will be performed within 30 days after discharge from the hospital.

☐ Circumcision is medically necessary for phimosis, paraphimosis or refractory balanitis.

☐ Other condition (please explain): _____

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: _____

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