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.

TRICARE Policy Manual, Chapter 8, Section 8.1 authorizes coverage of diabetes self-management training services for individuals with diabetes when medically necessary and appropriate, and coverage criteria are met.

MEDICAL HISTORY

In order for diabetes self-management training services to be covered, the physician who is managing the beneficiary's systemic diabetic condition must attest at least one of the following statements is true:

- ☐ The beneficiary has new onset diabetes.
- ☐ The beneficiary has poor glycemic control as evidenced by a glycosylated hemoglobin (HgbA1c) of 7.0 percent or more in the 90 days before attending the training.
- ☐ The beneficiary has had a change in treatment regimen from no diabetes medications to any diabetes medication or from oral diabetes medication to insulin.
- ☐ The beneficiary is at high risk for complications based on poor glycemic control with documented episodes of severe hypoglycemia or acute severe hypoglycemia occurring in the past year during which the beneficiary needed third party assistance for either emergency room visits or hospitalization.
- ☐ The beneficiary is at high risk based on at least one of the following documented complications:
  - Lack of feeling in the foot or other foot complications such as foot ulcer or amputation
  - Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye
  - Kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine
- ☐ Other: ______________________________

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PROVIDER REQUIREMENTS

In order for diabetes self-management training services to be covered, one of the following must be true:

- ☐ The provider is an otherwise authorized TRICARE provider who is Medicare-certified to provide diabetes outpatient self-management training services. (The provider must submit a copy of his or her "Certificate of Recognition" from the American Diabetes Association when billing.)
- ☐ The provider is an otherwise authorized TRICARE individual professional provider who also meets the National Standards for Diabetes Self-Management Education recognized by the American Diabetes Association.

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: ____________

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

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