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**.

TRICARE Policy Manual, Chapter 7, Section 2.2 and Chapter 13, Section 1.1 authorizes coverage of a screening mammogram (including a screening digital breast tomosynthesis [DBT], also known as 3-D mammography) for all women beginning at age 40, and for women who meet specific high-risk criteria beginning at age 30.

MEDICAL HISTORY

In order for screening mammography to be covered for women beginning at age 30, the provider must attest to the applicable statements below indicating the condition for which the screening mammogram is being ordered (check all that apply):

- ☐ A lifetime risk of 15 percent or greater of breast cancer (according to risk assessment tools based on family history such as the Gail mode, the Claus model or the Tyrer-Cuzick model). Or the beneficiary has one of the following risk factors:
  - ☐ History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH).
  - ☐ Extremely dense breasts when viewed by mammogram.
  - ☐ Known BRCA1 or BRCA2 gene mutation.
  - ☐ First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves.
  - ☐ Radiation therapy to the chest between the ages of 10 and 30 years.
  - ☐ History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with a history of one of these syndromes.

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