



Beneficiary Full Name:	Sponsor's SSN:
Date of Birth:	Beneficiary State of Residence:
Dear Provider,	
Please complete the letter of attestation below ar letter or attach it to your online request .	nd return as indicated on the additional information request
and supplies, including platelet rich plasma (PRP In order for PRP injections to be covered, the protreatment is being ordered: Patient is diagnosed with mild to moderate characters.	ovider must attest to the condition for which the
radiographic evidence of osteoarthritis is o	on file.
three months or is contraindicated, and evidence of diagnosis on physical exam is OR	nd occupational therapy has been unsuccessful after
· · · · · · · · · · · · · · · · · · ·	rate to the best of my knowledge. I understand Health Net routine audit and request the medical documentation to a 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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