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 8.1 authorizes coverage of endoscopic thoracic sympathectomy for the treatment of severe primary hyperhidrosis when appropriate nonsurgical therapies have failed and the hyperhidrosis causes significant functional impairment.

In order for endoscopic thoracic sympathectomy to be covered for primary hyperhidrosis, the provider must attest all of the following statements are true:

☐ The beneficiary has documented severe primary hyperhidrosis.

☐ The beneficiary has tried and failed appropriate nonsurgical therapies.

☐ The beneficiary's hyperhidrosis causes significant functional impairment.

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