Beneficiary Full Name: _____ Sponsor's SSN: _____ - _____ - _____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete this preconception and prenatal carrier screening tests letter of attestation below and return as indicated on the additional information request letter or attach it to your online request.

Per TRICARE Policy Manual, Chapter 6, Section 3.2, the following preconception and prenatal carrier screening tests may be covered: cystic fibrosis, spinal muscular atrophy, Fragile X syndrome, Tay-Sachs disease, hemoglobinopathies, and/or conditions linked with Ashkenazi Jewish descent. Coverage is limited to one test per condition per lifetime.

Medical History

The provider must answer the following questions for a preconception or prenatal carrier screening test to be authorized:

1. Is the requested testing for preconception/prenatal carrier screening only? ☐ Yes ☐ No
2. Has the patient previously been tested for this condition? ☐ Yes ☐ No

   If "Yes," explain medical necessity for repeat testing: _____

Please select the preconception/prenatal carrier screening test(s) being performed:

- ☐ Cystic fibrosis (CFTR)
- ☐ Spinal muscular atrophy (SMN1/SMN2)
- ☐ Fragile X syndrome (FMR1)
- ☐ Tay-Sachs disease (HEXA)
- ☐ Hemoglobinopathies (select which gene[s] are being tested):
  - ☐ HBA1/HBA2 (for example, alpha thalassemia)
  - ☐ HBB (for example, beta thalassemia,sickle cell anemia)

Testing for conditions linked with Ashkenazi Jewish descent:

Is the patient of Ashkenazi Jewish descent? ☐ **Yes** ☐ **No**

If yes, mark the gene(s) being tested below:

- ☐ All genes listed below

OR

- ☐ ABCC8-related hyperinsulinism (ABCC8)
- ☐ Bloom syndrome (BLM)
- ☐ Canavan disease (ASPA)
- ☐ Cystic fibrosis (CFTR)
- ☐ Familial dysautonomia (IKBKAP)
- ☐ Fanconi anemia group C (FANCC)
- ☐ Gaucher disease (GBA)
- ☐ Glycogen storage disease type 1A (G6PC)
- ☐ Joubert syndrome type 2 (TMEM216)
- ☐ Lipoamide dehydrogenase deficiency (DLD)
- ☐ Maple syrup urine disease type 1B (BCKDHB)
- ☐ Mucolipidosis type IV (MCOLN1)
- ☐ NEB-related nemaline myopathy (NEB)
- ☐ Niemann-Pick disease type A (SMPD1)
- ☐ Tay-Sachs disease (HEXA)
- ☐ Usher syndrome type 1F (PCDH15)
- ☐ Usher syndrome type 3 (CLRN1)

☐ **Other test (please specify):** _____

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: _____

Tax Identification Number (TIN): _____

Physician signature: _____ Date: _____

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108