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

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete Section 1 or 2 of the letter of attestation below and return as indicated on the additional information request letter or attach it to your **online request**. Be sure to include supporting clinical documentation, if applicable.

Section 1 (rape, incest, life of the mother endangered)

By law (10 USC 1093 and 32 CFR 199.4(e)(2)), elective abortions are not covered by TRICARE except in very limited circumstances. Coverage of abortion is limited to:

1. Pregnancy resulting from an act of rape or incest, or
2. Situations in which the life of the mother would be endangered if the fetus was carried to term.

Abortions performed for suspected or confirmed fetal abnormality (for example, anencephaly) or for mental health reasons (for example, threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under TRICARE. Payment is not allowed for any services involving preparation for, or normal follow-up to, a non-covered abortion.

In order for an abortion to be considered for coverage, the provider must attest to one of the statements as true. In addition, we require all applicable clinical documentation to support this attestation:

☐ Based on the information available to me and as documented in the beneficiary's medical record, I have concluded the pregnancy is the result of an act of rape and/or incest.

☐ The life of the mother would be endangered if the fetus was carried to term. **Note:** If you checked this box, we require the following information and supporting clinical documentation from the treating specialist that supports carrying the pregnancy to term threatens the life of the mother:

Diagnosis/medical condition of mother that is endangering her life if the fetus was carried to term:

Section II (spontaneous, missed or threatened abortions or ectopic, molar pregnancy)

By law (10 USC 1093 and 32 CFR 199.4(e)(2)), elective abortions are not covered by TRICARE except in very limited circumstances. Coverage of abortion is limited to:

1. Services and supplies related to spontaneous, missed or threatened abortions
2. Abortions related to ectopic pregnancy

Abortions performed for suspected or confirmed fetal abnormality (for example, anencephaly) or for mental health reasons (for example, threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under TRICARE. Payment is not allowed for any services involving preparation for, or normal follow-up to, a non-covered abortion.

In order for this procedure to be considered for coverage, the provider must attest that one of the following is true. In addition, we require clinical documentation such as clinical notes from visits, labs, and imaging to support this attestation:

- ☐ No fetal heart tones present
- ☐ No yolk sac
- ☐ Confirmed fetal demise
- ☐ Ectopic pregnancy
- ☐ Molar pregnancy

I attest the information provided is true and accurate to the best of my knowledge. I understand Heatlh 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 (Please submit clinical information) :

Physician's printed name and title: _____

TIN: _____

Physician's Signature: _____ Date: _____