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 8, Section 7.2 authorizes coverage of medically necessary foods.

In order for medically necessary foods to be considered for coverage, please attest the following criteria are met:

Section I. Covered disease or condition(s) and indicate applicable ICD-10 diagnosis code(s) in the space provided (check all that apply)

☐ Inborn Errors of Metabolism (IEM)
(Diagnosis code: _____)

☐ Medical conditions of malabsorption
(Diagnosis code: _____)

☐ Pathologies of the alimentary tract or the gastrointestinal tract; describe specific pathology
(Diagnosis code: _____)

☐ A neurological or physiological condition – describe specific condition
(Diagnosis code: _____)

☐ Other (Diagnosis code: _____)

Section II. Medically necessary food type being requested: (check all that apply)

☐ Specialized enteral formula listed online at www.health.mil/rates.

Specific brand name of formula: _____

_____

Amount of enteral formula requested and frequency of administration_____

_____

☐ Low protein modified food – provide detailed description of the type of food(s) to include specific brand name and vendor who will supply and bill TRICARE for reimbursement: _____

_____

Amount of food requested and frequency of ingestion*_____

☐ *The requested amounts and frequency of ingestion of formula and/or specialized solid foods noted above are medically necessary to avoid organ damage, grow properly, and/or maintain or improve health and represent appropriate medical care for this patient's condition(s) specified above.

☐ Ketogenic Diet:

☐ Patient has seizures that are refractory to standard anti-seizure medication. Provide specific brand name of formula listed online (www.health.mil/rates):

_____.

Section III. Medical Nutritional Therapy/Medical Nutritional Counseling

☐ Medical nutritional therapy/medical nutritional counseling under CPT codes 97802 – 97804 and/or HCPCS codes G0270 - G0271 with a physician, nurse, nutritionist, or registered dietician is required for the administration and maintenance of TRICARE covered medically necessary foods related to the covered disease(s) or condition(s) specified above. Indicate the frequency and duration of counseling visits and the total number of visits necessary (up to a maximum of 26 visits per year) _____.

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: _____