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 7, Section 6.2 authorizes coverage of lenses or eyeglasses for a limited number of medical conditions. In the absence of these conditions, corrective lenses are not a benefit.

INITIAL LENSES OR EYEGLASSES

In order for us to complete our medical review for requests for intial lenses or eyeglasses, the provider must attest one of the following statements is true:

- ☐ The beneficiary requires contact lenses for treatment of infantile glaucoma.
- ☐ The beneficiary requires corneal or scleral lenses for treatment of keratoconus.
- ☐ The beneficiary requires scleral lenses to retain moisture when normal tearing is not present or is inadequate.
- ☐ The beneficiary requires corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.
- ☐ The beneficiary requires intraocular lenses, contact lenses or eyeglasses to perform the function of the human lens, lost as the result of intraocular surgery or ocular injury, or congenital absence. Benefits for intraoculor lenses for this condition are limited to standard, fixed, non-accommodating monofocal lenses.

REPLACEMENT LENSES OR EYEGLASSES

When the prescription remains unchanged, replacement for lenses that are lost, have deteriorated or have become unusable due to physical growth is not covered.

In order for us to complete our medical review for requests for replacement lenses or eyeglasses, the provider must attest one of the following statements is true:

- ☐ The beneficiary requires contact lenses for infantile glaucoma and has a prescription change related to infantile glaucoma.
- ☐ The beneficiary requires corneal or scleral lenses for treatment of keratoconus and has a prescription change related to keratoconus.
- ☐ The beneficiary requires scleral lenses to retain moisture when normal tearing is not present or is inadequate. The beneficiary has a prescription change related to this condition.
- ☐ The beneficiary requires corneal or scleral lenses to reduce a corneal irregularity other than astigmatism and has a prescription change related to the corneal irregularity.
- ☐ The beneficiary requires intraocular lenses, contact lenses or eyeglasses to perform the function of the human lens, lost as the result of intraocular surgery or ocular injury, or congenital absence. The beneficiary has a prescription change related to aphakia.

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:_____ Physician's Signature: _____ Date: _____

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