HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

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 authorizes coverage for home health services. In order for 15 hours or more per week of skilled nursing to be covered, the provider must attest which of the following skilled needs are required and attach supporting documentation:

- ☐ ventilator, continuous
- ☐ ventilator, intermittent
- ☐ tracheostomy
- ☐ CPAP or BiPAP
- ☐ oxygen, continuous
- ☐ oxygen, intermittent
- ☐ G-tube, continuous
- ☐ G-tube, continuous with reflux
- ☐ NG-tube, continuous
- ☐ NG-tube, bolus
- ☐ IV therapy, continuous

Date of last hospitalization: _____

Reason for last hospitalization: _____

Other: _____

The provider must also attest which of the following interventions are required:

- ☐ tracheostomy change and care
- ☐ tracheostomy suctioning
  - ☐ every hour ☐ every 1–3 hours ☐ every 4 hours or greater
- ☐ NG-tube or G-tube feeds
  - ☐ continuous ☐ every 2–3 hours ☐ every 4 hours or greater
- ☐ dressing changes
  - ☐ every 8 hours ☐ every 9 hours or greater
- ☐ intermittent catheter changes
  - ☐ once a day or as needed ☐ every 4 hours ☐ every 8 hours ☐ every 12 hours
- ☐ IV/TPN
  - ☐ less than every 4 hours ☐ every 4–7 hours ☐ every 8–16 hours ☐ continuous

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

Special therapy required and description:

QID description: _____

TID description: _____

BID description: _____

QD description: _____

Specialized monitor description (for example, I&O): _____

_____

Medication: _____

Route: _____

Frequency: _____

Number of hours per day requested based on skilled needs (hours cannot be requested to cover employment, seeking employment, deployment or education of the primary caregiver): _____

Number of days per week: _____

I attest this beneficiary is either ☐ homebound or ☐ not homebound: _____

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: _____