

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 8, Section 11.1 authorizes coverage of routine podiatric care such as trimming of toenails when medically necessary because of a diagnosed systemic medical disease affecting the lower extremities.

In order for trimming or debriding of toenails to be covered, the provider must attest one of the following statements is true:

- The beneficiary has peripheral vascular disease (for example, atherosclerosis with impairment of circulation, thromboangiitis obliterans) affecting the lower extremities.
- The beneficiary has metabolic disease (for example, diabetes mellitus with sensory neuropathy, uremic peripheral neuropathy) affecting the lower extremities.
- The beneficiary has neurological disease (for example, chemotherapy induced peripheral neuropathy, harcot-marie-tooth sensory neuropathy) affecting the lower extremities.

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: _____

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L.104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

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