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 7, Sections 2.1 and 2.2 authorizes coverage of an osteoporosis screen when the following are met. Check all that apply:

- ☐ Female beneficiary is 65 years old or older.

or

- ☐ Female beneficiary is under 65 years old,
- ☐ postmenopausal, and
- ☐ has increased risk of osteoporosis as determined by a formal clinical assessment tool, including but not limited to:
  - ☐ Simple Calculated Osteoporosis Risk Estimation (SCORE),
  - ☐ Fracture Risk Assessment Tool (FRAX),
  - ☐ Osteoporosis Self-Assessment Tool (OSI),
  - ☐ Osteoporosis Risk Assessment Instrument (ORAI),
  - ☐ Osteoporosis Index of Risk (OSIRIS), or
  - ☐ other, please explain

    _____

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: _____

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