

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: _____

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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