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.

A prophylactic mastectomy is a limited benefit per TRICARE Policy Manual, Chapter 4, Section 5.3.

BILATERAL PROPHYLACTIC MASTECTOMY

For bilateral prophylactic mastectomies to be covered, the provider must attest the beneficiary is at increased risk of developing breast cancer due to one or more of the following (check all that apply):

- ☐ Patient has atypical hyperplasia of lobular or ductal origin confirmed on biopsy.
- ☐ Patient has a history of breast cancer in at least two first-degree relatives.
- ☐ Patient has at least two successive generations of family members with breast and/or ovarian cancer, also known as family cancer syndrome.
- ☐ Patient has a deleterious BRCA1 or BRCA2 mutation.
- ☐ Patient has fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate.

UNILATERAL PROPHYLACTIC MASTECTOMY

For unilateral prophylactic mastectomies to be covered, the provider must attest the beneficiary has been diagnosed with cancer in the contralateral breast and is at increased risk of developing breast cancer in the ipsilateral breast due to (check all that apply):

- ☐ Patient has been diagnosed with cancer in the contralateral breast.
- ☐ Patient has lobular carcinoma in situ.
- ☐ Patient previously elected observational surveillance for lobular carcinoma in situ and subsequently developed either invasive lobular or ductal carcinoma.
- ☐ Patient has a history of breast cancer in at least two first-degree relatives.
- ☐ Patient has at least two successive generations of family members with breast and/or ovarian cancer, also known as family cancer syndrome.
- ☐ Patient has a deleterious BRCA1 or BRCA2 mutation.
- ☐ Patient has diffuse microcalcifications in the remaining breast, especially when ductal carcinoma in situ has been diagnosed in the contralateral breast.
- ☐ Patient has a large and/or ptotic, dense or disproportionately-sized breast that is difficult to evaluate mammographically and clinically.

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: _____

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