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.

Prosthetics and orthotics are TRICARE covered benefits when medical necessary and when used for the treatment of an illness or injury, improve the function of a malformed, diseased or injured body part, or reduce further deterioration of the patient's physical condition.

Description of DMEPOS item(s) requested: _____

Billing Code:	Billing Code:	Billing Code:
Billing Code:	Billing Code:	Billing Code:

Medical rationale for prosthetic/orthotic: _____

Diagnostic Code:	Diagnostic Code:	Diagnostic Code:

Estimated length of need: _____

Request is for which of the following: ☐ new prosthetic/orthotic ☐ replacement ☐ repair

Please indicate which of the following apply:

☐ The prosthetic/orthotic is needed due to growth. The last time this was obtained was (insert date) _____

☐ The patient has had a change in condition.

Please explain: _____

☐ The prosthetic/orthotic was lost or stolen

☐ The prosthetic/orthotic is irreparably damaged

☐ The prosthetic/orthotic requires repair due to normal wear and tear

☐ The cost to repair the prosthetic/orthotic exceeds 60 percent of the cost of replacement.

Please explain: _____

☐ The prosthetic/orthotic is a duplicate of, or is similar to, prosthetic/orthotic already in use by the beneficiary.

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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