HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

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.

SECTION I

The beneficiary needs a home sleep study because:
(Please check one)

☐ The beneficiary has a high pretest probability of obstructive sleep apnea syndrome (OSAS) as evidenced by clinical features, signs and symptoms.
Please complete Section II and III.

☐ A diagnosis of OSAS has been established, therapy has been initiated and response to treatment is to be evaluated.
Please complete Section III.

SECTION II

Complete this section if the home sleep study is requested because the beneficiary has a high pretest probability of OSAS.
Please also complete Section III.

1. Does the beneficiary have a high pretest probability of OSAS due to the following conditions? (Check all that apply.)
   ☐ Age ☐ Gender ☐ High body mass index (BMI)
   ☐ Loud snoring ☐ Awakening with gasping or snoring
   ☐ Excessive daytime sleepiness
   ☐ Observed cessation of breathing during sleep
   ☐ Other **(Please explain condition in Section IV.)**
   ☐ None of the above
2. Has the ordering provider determined the home sleep study is an appropriate alternative to in-laboratory poly somnography (PSG)?
   ☐ Yes ☐ No
3. Does the beneficiary have any of the following co-morbidities? (Check all that apply.)
   ☐ Moderate to severe pulmonary disease
   ☐ Neuromuscular disease ☐ Congestive heart failure
   ☐ Other specific significant co-morbidity
   (Please explain in Section IV.)
   ☐ None of the above
4. Are any of the following sleep disorders suspected? (Check all that apply.)
   ☐ Central sleep apnea ☐ Periodic limb movement disorder
   ☐ Insomnia ☐ Parasomnia ☐ Circadian rhythm disorder
   ☐ Narcolepsy ☐ Other sleep disorder
   ☐ None of the above
5. Is the sleep complaint of short duration?
   ☐ Yes ☐ No
6. Does the beneficiary experience functional disability during the day due to the sleep-related disorder?
   ☐ Yes ☐ No

SECTION III

1. Has the sleep study been ordered by an authorized provider acting within the scope of his/her license?
   ☐ Yes ☐ No
2. What type of monitor is to be used?
   ☐ Type II ☐ Type III ☐ Type IV
3. Has the monitor been validated in a typical home environment?
   ☐ Yes ☐ No
4. Is the monitor an FDA-approved portable monitoring device?
   ☐ Yes ☐ No
5. Will test results be reviewed and interpreted by a physician who is board-eligible/board-certified in sleep medicine?
   ☐ Yes ☐ No

SECTION IV

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: _____

Provider's printed name and title: _____

TIN: _____ Signature: _____ Date: _____

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