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.

TRICARE Policy Manual, Chapter 4, Section 2.1 authorizes coverage of otoplasty when performed to correct congenital ear deformities such as microtia, lop ear and constricted ear.

Note: TRICARE policy excludes coverage of otoplasty performed for protruding and/or prominent ears. Otoplasty is not covered when performed as a cosmetic procedure.

MEDICAL HISTORY
In order for an otoplasty to be approved, the provider must certify one of the following statements is true:

- ☐ The beneficiary has microtia.
- ☐ The beneficiary has lop ear.
- ☐ The beneficiary has constricted ear.
- ☐ The beneficiary has the following congenital ear deformity: _____
- ☐ Other: _____

Please submit documentation of the physical exam findings and pre-operative photo documentation.

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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