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 and sign this letter of attestation below and return as indicated on the additional information request letter or attach it to your online request. *Requests for **Varithena®** (polidocanol injectable foam) must also include a copy of the Doppler or duplex ultrasound report that documents vein incompetence.*

1. Which of the following is the patient experiencing?
   - ☐ Persistent symptoms interfering with activities of daily living in spite of conservative/ non-surgical management
   - ☐ Significant recurrent attacks of superficial phlebitis hemorrhage from a ruptured varix
   - ☐ Ulceration from venous stasis where incompetent varices are a contributing factor
   - ☐ None of the above
2. Which symptoms are present, if any?
   - ☐ Aching
   - ☐ Cramping
   - ☐ Burning
   - ☐ Itching
   - ☐ Swelling during activity or after prolonged standing
   - ☐ None of the above
3. Which of the following conservative, non-operative treatments have been attempted?
   Please specify for how long and the response.
   - ☐ Mild exercise for _____ months.
     Response: _____
   - ☐ Avoidance of prolonged immobility for _____ months.
     Response: _____
   - ☐ Periodic elevation of legs for _____ months
     Response: _____
   - ☐ Compressive stockings for _____ months.
     Response: _____
   - ☐ Other (please specify treatment, duration, and response)
     _____
     _____
4. Is the patient's anatomy amenable to the procedure?
   ☐ Yes ☐ No
5. List of veins to be treated with Varithena (side, location is mandatory) and reflux measurements for all:
   _____
   _____
   _____
6. Prior endovenous treatments done, if any, and date performed:
   _____
   _____
7. If the request for Varithena is within three months of endovenous treatment and sclerotherapy, specify why a 3-month waiting period to determine the success of the endovenous procedure is not needed:
   _____
   _____

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: _____

Physician signature: _____ Date: _____