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.

CPT/HCPCS code requested: _____

TRICARE Policy Manual, Chapter 4, Section 6.1 authorizes coverage of vertebroplasty and balloon kyphoplasty when medically necessary and appropriate, and coverage criteria are met.

In order for vertebroplasty or balloon kyphoplasty to be covered, the provider must attest one or both of the following statements is true:

☐ The beneficiary has painful osteolytic lesions refractory to conservative medical treatment.

☐ The beneficiary has painful osteoporotic compression fractures refractory to conservative medical treatment

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