

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: \_\_\_\_\_

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L.104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

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