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 or attach it to your online request.

TRICARE coverage of a Continuous Glucose Monitoring System (CGMS) has been requested. The equipment must be ordered by a TRICARE-authorized provider. Additionally, the ordering provider must attest the beneficiary meets coverage criteria by completing and signing the following form. This information must be included with all initial requests for CGMS coverage.

1. Does the beneficiary have diabetes?
   ☐ Yes ☐ No
2. Please provide the name of the CGMS device requested:
   _____
3. Has the beneficiary completed a comprehensive diabetic education program?
   ☐ Yes ☐ No
4. Does the beneficiary have a treatment regimen that includes at least three insulin injections per day or insulin pump therapy, with frequent self-adjustment of insulin doses in the last three months (except for Type 1 diabetes, gestational diabetes and rare forms of diabetes, which have no time requirement for the self-adjustment of insulin)?
   ☐ Yes ☐ No ☐ N/A
5. Is there documentation of the beneficiary blood glucose self-testing on average of at least four times per day prior to initiation of CGMS therapy?
   ☐ Yes ☐ No
6. The beneficiary has one of the following (please check all that apply):
   - ☐ Glycosylated hemoglobin level (HBA1c) is greater than 7.0% or less than 4.0%.
   - ☐ History of unexplained, large fluctuations in daily glucose values before meals.
   - ☐ History of early morning fasting hyperglycemia ("dawn phenomenon").
   - ☐ History of severe glycemic excursions.
   - ☐ Hypoglycemic unawareness.
   - ☐ History of recurrent, unexplained, severe hypoglycemic events (i.e., blood glucose less than 50 mg/dl).
   - ☐ History of recurrent episodes of ketoacidosis.
   - ☐ Hospitalizations for uncontrolled glucose levels.
   - ☐ Has frequent nocturnal hypoglycemia.
   - ☐ Is pregnant and has poorly controlled diabetes or gestational diabetes.
   - ☐ None of the above. Please indicate your rationale for requesting CGMS equipment for this beneficiary in additional information section below.

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:

_____

_____

Authorized prescribing provider's printed name and title:_____

TIN: _____ Signature:_____ Date: _____



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