

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.

The use of home prothrombin time (PT)/international normalized ratio (INR) monitoring devices are a limited benefit under TRICARE Policy Manual, Chapter 8, Section 2.5.

In order for PT/INR devices to be covered, the provider must attest all of the following statements are true:

- The patient has a medical condition requiring lifetime warfarin therapy and monitoring of prothrombin time activity.
- The patient requires frequent prothrombin time testing once a week or multiple times per month.
- The patient (or patient's caregiver) has the ability to use the prothrombin time monitoring device after obtaining education on its proper use from an appropriate health care professional.
- The device has U.S. Food and Drug Administration (FDA) approved.

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 1-877-TRICARE at once and destroy the documents and any copies you have made.

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