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.

Ultrasonic Bone Growth Stimulators – E0760 and 20979

☐ Request is for non-invasive, low-intensity pulsed ultrasound treatment for fresh fractures or fusions (arthrodesis)*

*NOTE: Fresh fractures are defined as fractures that have recently occurred and have not had any previous treatment (other than emergency splinting prior to evaluation and fixation).

Mark all of the following that apply to the individual:

- ☐ Individual has a closed radial fracture (for example, Colles' fracture).
- ☐ Individual has a closed tibial diaphyseal fracture.
- ☐ Individual has a Grade I open tibial diaphyseal fracture.
- ☐ Individual has a closed fracture at high risk for nonunion due to location and/or poor vascular supply (for example, carpal navicular/scaphoid fractures, Jones/fifth metatarsal fracture).
- ☐ Individual has a closed fracture site at high risk for nonunion due to associated extensive soft tissue or vascular damage.
- ☐ Individual has a closed fracture at high risk for nonunion due to comorbidity. If checked, mark all of the following that apply:
  - ☐ alcoholism
  - ☐ anemia (severe)
  - ☐ BMI > 30
  - ☐ diabetes (where bone healing may be compromised)
  - ☐ kidney disease (where bone healing may be compromised)
  - ☐ metabolic disease (where bone healing may be compromised)
  - ☐ nutritional deficiency
  - ☐ steroid therapy
  - ☐ tobacco abuse
  - ☐ other: _____

☐ Request is for non-invasive, low-intensive ultrasound treatment for fracture non-union of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal)**

**NOTE: Fracture non-union is a fracture in which all evidence of bone growth activity at the fracture site has ceased leaving a persistent unhealed fracture of the bone.

If checked, mark all that apply:

- ☐ At least 45 days have passed since the date of the fracture.
- ☐ At least 45 days have passed since the date of appropriate fracture care.
- ☐ Serial radiographs or other imaging studies confirm there is no evidence of progression of healing.
- ☐ The fracture gap is less than one centimeter.
- ☐ Other: _____

☐ Request is for indication other than those mentioned above: _____.

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: _____