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.

TRICARE Policy Manual, Chapter 7, Section 3.8 authorizes coverage of transcranial magnetic stimulation (TMS) when medically necessary and consistent with coverage criteria.

In order for TMS to be covered, the care must be prior authorized and the provider must attest that the following statement is true:

- ☐ Beneficiary is 18 years or older, and
- ☐ The beneficiary has failed to respond to a less intensive form of treatment, or
- ☐ A less intensive intervention is not more appropriate.

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: _____

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