

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: \_\_\_\_\_

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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