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 letter or attach it to your online request.

TRICARE Policy Manual, Chapter 4, Section 13.2 authorizes coverage for bariatric revision surgery when specific conditions are met.

Prior to initial surgery:

Beneficiary height: _____ Beneficiary weight: _____ Beneficiary body mass index (BMI): _____

Date of original procedure: _____ Type of original procedure: _____

Current:

Beneficiary height: _____ Beneficiary weight: _____ Beneficiary body mass index (BMI): _____

Please complete **Section I, Section II**, **Section III** and **Section IV** below based on the reason for the revision of bariatric surgery.

Section I

Is this for a bariatric surgery reversal (takedown or reversal) due to a complication of the original covered surgery?

☐ Yes ☐ No

If yes, please indicate which of the following complications applies:

☐ stricture ☐ obstruction ☐ fistula ☐ other

(please explain): _____

_____

Section II

Is the requested revision procedure the replacement or removal of an adjustable band, required due to a complication that cannot be corrected with band manipulation or adjustment?

☐ Yes ☐ No

If yes, complete the following:

a. Replacement is required due to one of the following:
   ☐ port leakage ☐ slippage ☐ tubing or valve malfunction

b. Removal is required due to persistent reflux or gastritis with which of the following:
   ☐ patient has symptoms of reflux (for example, pain, heart-burn, nausea, vomiting)
   ☐ treatment of reflux or gastritis has failed medical management
   ☐ removing fluid from the band has not relieved the reflux or gastritis
   ☐ esophagogastroduodenscopy (EGD) has demonstrated evidence of reflux or gastritis

c. Was the beneficiary's original adjustable gastric banding procedure covered by TRICARE at the time it was performed?
   ☐ Yes ☐ No

Section III

Does the beneficiary require a repeat or revision procedure due to the technical failure of a previous covered bariatric surgical procedure? ☐ Yes ☐ No

If yes, complete the following:

a. Has the beneficiary failed to achieve adequate weight loss (failure to lose at least 50% of excess body weight or failure to achieve body weight to within 10% of ideal body weight at least two years following the original surgery)? ☐ Yes ☐ No

b. Has the beneficiary met **all** the screening criteria, including **BMI** requirements of the original procedure and has he or she been compliant with a prescribed nutrition and exercise program following the original surgery?
   ☐ Yes ☐ No

Section IV

Choose **all** that apply:

☐ No drug or alcohol misuse by history or drug and alcohol free period for one year or more.
☐ No psychiatric disorder by history or psychiatric disorder managed.
☐ No cigarette smoking by history or smoke free period 6 weeks or more.
☐ Patient has understanding of the surgical procedure, post procedure compliance, and follow-up care.
☐ Other clinical information: (add comment)

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: _____

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108