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 4, Section 6.1 authorizes coverage of femoroacetabular impingement (FAI) surgery when all of the following criteria is met:

☐ moderate to severe and persistent activity-limiting hip pain that is worsened by flexion activities;

☐ physical examination consistent with the diagnosis of FAI (at least one below must apply):

    ☐ positive impingement sign (pain when bringing the knee up towards the chest and then rotating it inwards towards your opposite shoulder); or

    ☐ Flexion Abduction External Rotation (FABER) provocation test (the test is positive if causes pain or limits the range of motion of the hip being tested); or

    ☐ posterior inferior impingement test (the test is positive if it causes similar pain as complained by the patient).

☐ failure to improve with greater than three months of conservative treatment (for example, physical therapy, activity modification, non-steroidal anti-inflammatory medications, intra-articular injection.). Request must document what and how long conservative treatments were used; and

☐ radiographic evidence of FAI is present; and

☐ absence of advanced arthritis.

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: _____