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 covers medically-necessary COVID-19 antibody (serology) testing to diagnose and/or treat a beneficiary. An approval from HNFS is not required. TRICARE does not cover serology testing performed for return to work or school or for public health surveillance. This is consistent with direction to health plans under the CARES Act. Find current benefit details at www.tricare-west.com > *Provider* > *Benefits A–Z* > *Coronavirus Testing*.

In order for COVID-19 antibody (serology) testing to be considered for coverage, the provider must indicate the reason for testing and the name of the test being used:

- ☐ The patient is exhibiting acute or delayed signs/symptoms of COVID-19.
- ☐ For screening purposes of an asymptomatic patient.
  - ☐ Required for scheduled medical procedure or appointment. Lack of test would affect access to needed medical care or result may change the care provided.
  - ☐ To determine an employee's ability to return to work.
  - ☐ To determine a student's ability to return to school.
  - ☐ Patient just wants to know if they may have had COVID-19 at some point in the past.
- ☐ To determine a potential donor's ability to donate blood or plasma.
- ☐ Testing is being requested as part of epidemiological research, surveillance studies or for other public health reasons.
- ☐ Other indication(s): *Please describe*

_____

Specific Emergency Use Authorizations (EUA) COVID-19 antibody (serology) Test Name:

_____

(For example: Abbott Architect SARS-CoV-2 IgG, Bio-Rad Platelia SARS-CoV-2 Total Ab, Roche Elecsys Anti-SARS-CoV-2, etc…)

Note: Testing information can be found at https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations.

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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