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 5, Section 1.1 states diagnostic breast magnetic resonance imaging (MRI) (CPT® procedure codes 77058 and 77059) is only covered for specific indications.

MEDICAL HISTORY

In order for a diagnostic breast MRI to be considered for coverage, the provider must attest to the applicable statements below indicating the condition for which the breast MRI is being ordered:

- ☐ To detect breast implant rupture (The implantation of the breast implants must have been covered by TRICARE.)
- ☐ For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography
- ☐ For pre-surgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization
- ☐ For pre-surgical planning to evaluate the presence of multicentric disease in patients with localized or locally advanced breast cancer who are candidates for breast conservation treatment
- ☐ Evaluation of suspected cancer recurrence
- ☐ To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor
- ☐ For guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI
- ☐ For evaluation of the contralateral breast when the patient has been newly diagnosed with breast cancer
- ☐ To evaluate patients with metastatic cancer when the primary is unknown and suspected to be of breast origin
- ☐ Lesion characterization when physical exam or other imaging examination such as ultrasound and mammography are inconclusive for the presence of breast cancer and biopsy could not be performed (for example, a distortion on only one mammographic view without a sonographic correlate)
- ☐ For assessment of the chemotherapeutic response and residual disease after chemotherapy
- ☐ For evaluation of residual disease in patients with close or positive lumpectomy margins
- ☐ To determine whether additional foci of malignant disease is present elsewhere in the ipsilateral breast in patients diagnosed with localized disease (i.e. ductal carcinoma in situ (DCIS) or invasive carcinoma
- ☐ For other indications when documented by reliable evidence as safe, effective and comparable to conventional technology (proven). Please specify:

_____

_____

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