

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 electroconvulsive therapy (ECT) when medically necessary and consistent with coverage criteria.

In order for ECT to be covered, the care must be prior authorized and the provider must attest that the following statement is true:

- 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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