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 1.2 and 3.2 authorizes coverage of hormone therapy/endocrine treatment for gender dysphoria. In order for this endocrine treatment to be considered for coverage, please attest to the sections below as applicable:

Section I Adults (age 18 and over)
Cross-sex hormone treatment in adults is authorized when (please check all of the following that apply):

- ☐ A diagnosis of gender dysphoria was made by a TRICARE-authorized mental health provider according to most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM),
- ☐ No psychiatric comorbidity is present that would confound a diagnosis of gender dysphoria or interfere with treatment (for example, unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment), and
- ☐ A documented minimum of three months of Real-Life Experience (RLE) and/or three months of continuous psychotherapy addressing gender transition as an intervention for gender dysphoria.

Section II Adolescents
Cross-sex hormone treatment in adolescents is authorized when (please check all of the following that apply):

- ☐ A diagnosis of gender dysphoria was made by a TRICARE-authorized mental health provider according to most current edition of DSM,
- ☐ The beneficiary has experienced puberty to at least Tanner stage two,
- ☐ The beneficiary is 16 years or older,
- ☐ No psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment exists (for example, unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment), and
- ☐ A documented minimum of three months RLE and/or three months of continuous psychotherapy addressing gender transition as an intervention for gender dysphoria.

Section III Prepubertal Suppression

- ☐ Child is prepubertal (hormone therapy for prepubertal suppression is not covered), or
- ☐ Adolescent has experienced puberty to at least Tanner stage 2, and
- ☐ This is a request to suppress puberty with gonadotropin-releasing hormone analogues (GnRH).

GnRH drug name is: _____

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