HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

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 or attach it to your **online request**.

TRICARE Operations Manual, Chapter 17, Section 3 authorizes coverage of maintenance of a wakefulness test (MWT) for obstructive sleep apnea (OSA), when requested for an active duty service member to determine the effectiveness of treatment. In order for MWT to be considered for coverage, the provider must attest all of the following statements are true:

☐ Patient was diagnosed with OSA and has received at least 30 days of described treatment (for example, continuous positive airway pressure).

☐ Positive airway pressure usage as prescribed is as follows (if applicable):

_____ hours used on _____ percent of nights since initiation of treatment on this date _____.

If treatment prescribed was not positive airway pressure, please describe type of treatment:

_____

☐ The nearest military hospital or clinic with a sleep disorder center and sleep lab cannot accommodate the request for MWT.

☐ A network civilian sleep facility that is American Academy of Sleep Medicine (AASM) certified will be performing the MWT. (AASM verification website: **https://aasm.org/accreditation/accreditation-verification/**)

☐ Prior to conducting the MWT, the sleep lab shall document positive airway pressure usage and compare to Service-specific compliance requirements. Unless the referral specifies otherwise, the required positive airway pressure usage compliance should be assumed to be four hours per night, 70% of the time. If a higher level of compliance is specified in the referral, please attest to the higher compliance level.

☐ Patient meets Service-specific positive airway pressure usage compliance standards.

(**Note:** If compliance requirements are met, the sleep lab may proceed with the MWT. If the compliance requirements are NOT met, the sleep lab will not proceed with the MWT and report the results with the referring provider).

Active duty service members treated with surgical therapy:

☐ A post-operative polysomnography was performed confirming an apnea hypopnea index (AHI) less than five per hour documented on the referral.

(**Note:** The test results should be included with the request.)

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.

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved. • HF0619x008 (09/24)