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.

Please complete the questions below for TRICARE beneficiaries requesting care from a non-network provider, seeking continuity of care from a non-network provider or requesting care under the TRICARE Prime Travel Benefit (from a network or non-network provider).

Is the request for care in the TRICARE West Region West region (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa [excludes Rock Island arsenal area], Kansas, Minnesota, Missouri [except St. Louis area], Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas [southwestern corner including El Paso], Utah, Washington and Wyoming?

☐ Yes ☐ No

Is the beneficiary traveling?

☐ Yes ☐ No

Does the beneficiary live part of the year in another TRICARE region (for example, college student)?

☐ Yes ☐ No

Is the beneficiary requesting to use this provider?

☐ Yes ☐ No

Is the servicing provider more than 100 miles from the primary care manager's address?

☐ Yes ☐ No

Date of last appointment with the requested provider (if applicable): __________________

Frequency of visits: ______________________________

Weekly number of visits per week: ___________________

Monthly number of visits per month: ___________________

Yearly number of visits per year: ____________________

Other: ____

Did Health Net Federal Services, LLC issue a previous approval to the requested provider?

☐ Yes ☐ No

Please provide rationale for use of this provider; include nature of any intensive treatments or unique therapies the beneficiary is receiving.

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Please provide rationale why care cannot be transitioned to another provider.

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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.

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108

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