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.

The use of home prothrombin time (PT)/international normalized ratio (INR) monitoring devices are a limited benefit under TRICARE Policy Manual, Chapter 8, Section 2.5.

In order for PT/INR devices to be covered, the provider must attest all of the following statements are true:

- ☐ The patient has a medical condition requiring lifetime warfarin therapy and monitoring of prothrombin time activity.
- ☐ The patient requires frequent prothrombin time testing once a week or multiple times per month.
- ☐ The patient (or patient's caregiver) has the ability to use the prothrombin time monitoring device after obtaining education on its proper use from an appropriate health care professional.
- ☐ The device has U.S. Food and Drug Administration (FDA) approved.

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 9470 • Virginia Beach, VA 23450-9470