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 4, Section 20.1 states non-pulsed radiofrequency (RF) denervation is a covered benefit in limited circumstances.

Note: Pulsed RF denervation is not a TRICARE covered benefit.

MEDICAL HISTORY

In order for non-pulsed RF denervation to be covered, the provider must attest to the applicable statements below indicating the condition for which the test is being ordered:

☐ The beneficiary has undergone spinal fusion surgery at the vertebral level being treated, or

☐ The beneficiary has not undergone spinal fusion surgery at the vertebral level being treated.

The beneficiary has lumbosacral or cervical pain suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations.

☐ Yes ☐ No

The beneficiary has localized pain that does not radiate to any other part of the body at the vertebra level being treated.

☐ Yes ☐ No

The beneficiary's pain has failed to respond to at least three months of conservative management (for example, acetaminophen, nonsteroidal anti-inflammatory medications, manipulation, physical therapy or home exercise program).

☐ Yes ☐ No

A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50 percent reduction in pain.

☐ Yes ☐ No

Check all that apply (if applicable):

☐ The beneficiary has no prior RF denervation of the area being currently treated.

☐ The beneficiary has had prior successful RF denervation and at least six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

☐ The beneficiary has had prior successful RF denervation within the last six months (per side, per anatomical level of the spine).

Date of most recent RF denervation (if applicable): _____

What level of the spine are you requesting authorization for treatment? _____

What side of the side of the body are you requesting authorization for treatment? _____

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: _____

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