



Beneficiary Full Name:	Sponsor's SSN:		
Date of Birth:	Beneficiary State of Residence:		
Dear Provider, Please complete the letter of attest request letter.	tation below and return a	as indicated on the additi	onal information
TRICARE authorizes coverage for nursing to be covered, the provice attach supporting documentation	ler must attest which of t	the following skilled need	ls are required and
<ul><li>□ ventilator, continuous</li><li>□ ventilator, intermittent</li><li>□ tracheostomy</li><li>□ CPAP or BiPAP</li></ul>	<ul><li>oxygen, continuous</li><li>oxygen, intermitten</li><li>G-tube, continuous</li><li>G-tube, continuous</li></ul>	nt	tube, continuous tube, bolus nerapy, continuous
Date of last hospitalization:			
Reason for last hospitalization:			
Other:			
The provider must also attest while tracheostomy change and care tracheostomy suctioning	_	ventions are required:	
$\square$ every hour $\square$ every 1–3 hours $\square$ every 4 hours or greater			
☐ NG-tube or G-tube feeds			
$\square$ continuous $\square$ every 2–3 hours $\square$ every 4 hours or greater			
☐ dressing changes			
every 8 hours every 9 hours or greater			
$\square$ intermittent catheter changes			
$\square$ once a day or as needed	every 4 hours	every 8 hours	every 12 hours
□ IV/TPN			
$\square$ less than every 4 hours	every 4–7 hours	every 8–16 hours	☐ continuous

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

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Special therapy required and description:
QID description:
TID description:
BID description:
QD description:
Specialized monitor description (for example, I&O):
Medication:
Route:
Frequency:
Number of hours per day requested based on skilled needs (hours cannot be requested to cover employment, seeking employment, deployment or education of the primary caregiver):
Number of days per week:
I attest this beneficiary is either $\square$ homebound or $\square$ not homebound:
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: