

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 submit via fax along with a TRICARE Service Request/Notification Form to 1-888-299-4181.

**Section I**

The beneficiary needs a continuous glucose monitoring system (CGMS) equipment for **(please check one)**:

- Short-term (up to 72 hours) intermittent (up to six times per year) use. **Please complete Section II below.**
- Long-term (greater than 72 hours) continuous or periodic use. **Please complete Section II and III below.**

**Section II**

Complete this section whether the request is for short or long-term use of CGMS equipment. If the request is for long-term use, please complete Section III.

1. Does the beneficiary have type 1 diabetes mellitus?  
 Yes  No
2. Will the beneficiary be required to perform at least four self-monitoring blood glucose checks daily while using CGMS equipment?  
 Yes  No
3. Is the beneficiary compliant with recommended medical regimens?  
 Yes  No
4. Has the beneficiary (or parent if beneficiary is a young child) completed a comprehensive diabetic education program?  
 Yes  No
5. Have appropriate modifications in the beneficiary's insulin regimen been implemented?  
 Yes  No

6. Please check all of the following that apply. The beneficiary has:

- An HbA1c which is greater than 9.0 percent or less than 4.0 percent
- A history of unexplained, large fluctuations in daily glucose values before meals (greater than 150 mg/dl)
- A history of early morning fasting hyperglycemia ("dawn phenomenon")
- A history of severe glycemic excursions
- Hypoglycemic unawareness
- None of the above. Please indicate your rationale for requesting CGMS equipment for this beneficiary in the comments section.

**Section III**

Please complete this section if the request is for long-term use of CGMS equipment. Complete this section in addition to Section II. Please check all of the following that apply.

The beneficiary:

- Has a history of recurrent, unexplained, severe hypoglycemic events or hypoglycemic unawareness (i.e., blood glucose less than 50 mg/dl)
- Has a history of recurrent episodes of ketoacidosis
- Has been hospitalized for uncontrolled glucose levels
- Has frequent nocturnal hypoglycemia
- Is pregnant and has poorly controlled type 1 diabetes or gestational diabetes
- Has none of the above. Please indicate your rationale for requesting CGMS equipment for this beneficiary in the comments section.

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 1-877-TRICARE at once and destroy the documents and any copies you have made.

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