Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the banked donor milk coverage criteria attestation and submit it, along with the prescription, with your initial claim or as indicated on the additional information request within 14 days of the letter to:

TRICARE West Claims
PO Box 202112
Florence, SC 29502-2112
Fax: 1-844-869-2504

TRICARE Policy Manual Chapter 8, Section 7.2 authorizes coverage of medically necessary foods.

In order for claims for banked donor milk to be approved, the provider must certify all of the following statements are true:

☐ The infant has one or more of the following conditions (check all that apply):

- ☐ birth weight of 1,500g or lower,
- ☐ gastrointestinal anomaly, metabolic/digestive disorder, or recover from intestinal surgery where digestion requires additional support,
- ☐ diagnosed failure to thrive and other feeding options have been exhausted or are contraindicated,
- ☐ formula intolerance with either documented feeding difficulty or weight loss and other feeding options have been exhausted or are contraindicated,
- ☐ hypoglycemia,
- ☐ congenital heart disease,
- ☐ pre- or post-organ transplant, or
- ☐ other serious health condition and the use of banked donor milk is medically necessary and will support the treatment recovery for the infant.

and

☐ Mother's milk is contraindicated, unavailable due to medical or psychological condition or is insufficient in quantity or quality to meet the infant's dietary need. It may also be covered due to the birth mother's physical absence (for example, adoption, maternal death or deployment of the active duty service member mother),

and

☐ Banked donor milk will be procured through a Human Milk Banking Association of North American (HMBANA) accredited milk bank and delivered through a TRICARE-authorized provider (for example, pediatrician, inpatient hospital or supplier [HMBANA-accredited milk bank]),

and

☐ Coverage is limited to no more than 35 ounces per day,

and

☐ Banked donor milk was prescribed by a TRICARE-authorized individual professional provider described in 32 CFR 199.6 (licensed by the state in which the care is provided and must be under the supervision of a physician (if not a physician) who is overseeing the episode of treatment or the covered program of services.

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: _____