ECHO HOME HEALTH CARE ATTESTATION FORM

*Required

*Beneficiary Name:	*Date of Birth (MM/DD/YYYY):

In order to qualify for Extended Care Health Option (ECHO) Home Health Care (EHHC), the TRICARE beneficiary must be homebound and have skilled needs. TRICARE Policy Manual Chapter 9, Section 15.1 (ECHO Home Health Care (EHHC)) requires the provider attest that the beneficiary is homebound. Please complete the attestation and identify the skilled needs required. This documentation will be required annually and with treatment changes.

Homebound

In order for this beneficiary to be eligible for EHHC, your attestation confirming the beneficiary is homebound as defined in TRICARE Policy Manual (TPM) Ch. 9, Sect. 15.1.para. 6.1.1- 6.1.2 is required. Although this definition indicates that a beneficiary's participation in a day care center or educational program does not disqualify them from EHHC or respite care, it does not indicate that such services will be paid for if provided outside the beneficiary's primary residence. EHHC services and respite care services will be cost-shared by TRICARE only when such services are provided in the beneficiary's primary residence. TRICARE does not pay for nurses to accompany beneficiary to school, during school hours, or while beneficiary is traveling from school to home.

EHHC Services and Respite Care Services

Per (TPM) Ch. 9, Sect. 15.1 para. 7.3 EHHC services and EHHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education. Except for those excluded activities, this exclusion does not otherwise restrict or prohibit the primary caregiver(s) from engaging in other activities they choose, including those outside the beneficiary's primary residence.

Skilled Needs

Please identify skilled need as defined in TRICARE Policy Manual (TPM) Ch. 9, Sect. 15.1 para 5.1.1.3-5.1.1.4: "The beneficiary requires medically necessary skilled services beyond the level of coverage provided by the TRICARE HHA PPS; and/or the beneficiary requires frequent interventions that are normally provided by the beneficiary's primary caregiver(s)." Please enclose supporting documentation for each.

Technology *(check all that apply)*

- ☐ Ventilator, continuous
- ☐ Ventilator, intermittent
- ☐ Tracheostomy
- ☐ CPAP, BiPAP
- ☐ Oxygen, continuous
- ☐ Oxygen, intermittent
- ☐ G/NG-tube, continuous
- ☐ G/NG-tube, continuous with reflux
- ☐ IV therapy, continuous
- ☐ Last hospitalization: _____
- ☐ Other: _____

***Private Duty Nursing**

_____ hours per day and _____ days per week

PT- G0151 _____ hours per week

OT- G0152 _____ hours per week

ST- G0153 _____ hours per week

Interventions *(check all that apply)*

- ☐ Trach suctioning: ☐ Q1 hr ☐ Q1-4 hrs ☐ ≥Q4 hrs
- ☐ G/NG Tube feeds: ☐ continuous ☐ 1-4 hrs ☐ ≥Q4 hrs
- ☐ Dressing changes: ☐ ≤Q8 hrs ☐ ≥Q8 hrs
- ☐ Intermittent cath: ☐ Q4 hr ☐ Q8 hr ☐ Q12 hr ☐ QD/prn
- ☐ IV/TPN: ☐ continuous ☐ Q8-16 hrs ☐ ≥Q4-7 hrs ☐ ≤Q8 hrs
- ☐ Special therapy/description
  - QID Description: _____
  - TID Description: _____
  - BID Description: _____
  - QD Description: _____
- ☐ Specialized monitor description (for example, I&O): _____
- ☐ Medication/route/frequency: _____

I attest this beneficiary:

☐ is homebound ☐ is not homebound

*Provider's Signature:	*Provider's Printed Name:	*Date (MM/DD/YYYY):

Please fax this completed form to 866-670-3821.