Cope Prosthetics Inc.
25405 Hancock Ave, #213
Murrieta, CA 92562
951-799-1499

Therapeutic Diabetic Shoes & Inserts – Documentation Request

Dear Physician,

Thank you for assisting us in providing our mutual patient with therapeutic diabetic shoes and custom inserts.

To meet Medicare and insurance coverage requirements, please provide the following documentation from the certifying physician:

☐ **Prescription / Standard Written Order (SWO)**

- The prescribing provider may be a physician (MD/DO), podiatrist, nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS).
- The Standard Written Order must be completed, signed, and dated by the prescribing provider.

☐ **Clinical Evaluation / Medical Record Documentation**

Please provide copies of the following office visit notes from the patient's medical record:

Diabetes Management

- Documentation demonstrating ongoing management of the patient's diabetes.
- The office visit must have occurred within **6 months prior to the delivery** of the therapeutic shoes and inserts.

Foot Evaluation

- Documentation of a comprehensive foot examination identifying a qualifying diabetic foot condition.
- The foot evaluation must have been completed within **6 months prior to delivery** of the shoes and/or inserts.

The foot evaluation may be performed by:

1. The certifying physician (MD/DO); **or**
2. Another qualified healthcare provider, such as a podiatrist, nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS).

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If the foot evaluation is completed by a provider listed in Option 2, the certifying physician must:

- Review the documentation;
- Sign and date the office note; and
- Include a statement indicating agreement with the findings before submitting the documentation to the supplier.

☐ **Statement of Certifying Physician for Therapeutic Shoes**

- This form must be completed, signed, and dated by the certifying physician (MD or DO).
- The certification must be signed **on or after the date of the qualifying office visits** and **within 3 months prior to delivery** of the therapeutic shoes.
- The statement must certify:
    - The patient has diabetes mellitus.
    - The patient meets the Medicare qualifying criteria for therapeutic footwear.
    - Therapeutic shoes and/or inserts are medically necessary as part of the patient's comprehensive diabetes treatment plan.

Important Provider Signature Requirement

If the **Statement of Certifying Physician** or the **diabetes management office notes** are completed or signed by a Nurse Practitioner (NP) or Physician Assistant (PA), the supervising **MD or DO** under whose supervision the services were provided must:

- Review the documentation;
- Sign and date the records; and
- Indicate agreement with the findings and recommendations.

Providing complete documentation helps avoid delays in processing and ensures timely delivery of the patient's therapeutic footwear.

Thank you for your prompt attention and partnership in caring for our mutual patient.

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This form must be completed by the certifying physician:

Patient Name: _____ **DOB:** _____

Medicare ID: _____ **Date of Foot Exam:** _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. The patient has one or more of the following conditions (Check all that apply)
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot Deformity
   - ☐ Poor Circulation
3. I am treating this patient under a comprehensive plan for his/her diabetes
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes
5. The above information is documented in the patient's medical record

Signature, Name, Date and NPI (Must be signed by an M.D. or D.O.)

Signature: _____ **Date:** _____

Printed Name: _____ **Credential: MD DO**

Address: _____

Phone: _____ **Fax:** _____

NPI: _____