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.

TRICARE Policy Manual, Chapter 8, Section 8.21 authorizes coverage of extra-depth shoes with inserts or custom molded shoes with inserts for individuals with diabetes when medically necessary and appropriate, and coverage criteria are met.

MEDICAL HISTORY

In order for diabetic shoes, inserts and other shoe modifications to be covered, the physician (MD or DO) who is managing the beneficiary's systemic diabetic condition must attest the beneficiary has one or more of the following conditions. Please indicate which condition has been documented by the beneficiary's physician:

- ☐ The beneficiary has diabetes, is being treated under a comprehensive plan of care for his/her diabetes and needs therapeutic shoes because of a previous amputation of the foot or part of the foot.
- ☐ The beneficiary has diabetes, is being treated under a comprehensive plan of care for his/her diabetes and needs therapeutic shoes because of a history of previous foot ulceration.
- ☐ The beneficiary has diabetes, is being treated under a comprehensive plan of care for his/her diabetes and needs therapeutic shoes because of pre-ulcerative callus formation or peripheral neuropathy with a history of callus formation, foot deformity or poor circulation.

REQUESTED DIABETIC SHOES

For each individual, coverage of the footwear and inserts is limited to one of the following options within one calendar year. Please indicate which option is selected for this beneficiary:

- ☐ One pair of custom molded shoes (including inserts provided with such shoes) and two pairs of multidensity inserts
- ☐ One pair of custom molded shoes (including inserts provided with such shoes) and one pair of multidensity inserts, with modification of the shoe(s) (e.g., rigid rocker bottoms, roller bottoms, metatarsal bars, wedges, offset heels) as a substitute for one insert/one pair of inserts
- ☐ One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of multidensity inserts
- ☐ One pair of extra-depth shoes (not including inserts provided with such shoes) and two pairs of multidensity inserts with modification of the shoe(s) (e.g., rigid rocker bottoms, roller bottoms, metatarsal bars, wedges or offset heels) as a substitute for one insert/one pair of inserts

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: _____

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