

DALE'S SHOES AND PEDORTHICS

Phone: 386-252-2138

453 South Nova Road

Ormond Beach, FL 32174

**dale's
shoes**

and pedorthics

dalesshoes.com

Customer Info:

Date: _____

Patient: _____

D.O.B.: _____

Re: Diabetic Footwear Documentation Request

Dear _____

**We must have this paper work in order
for your patient to qualify for the therapeutic shoe benefit...or
MEDICARE WILL DENY THEIR CLAIM!**

- 1** Fill out the statement of certifying physician. This **MUST** be completed and signed by the MD or DO managing the patient's diabetic condition.
 - 2** Fill out the detailed written order.
 - 3** Complete the foot evaluation and supply us with a copy of the latest office visit note documenting an in-person meeting with the doctor and that the patient is being treated under a comprehensive plan of care for their diabetes.
- OR** A copy of the most recent office visit note as above that also documents the qualifying condition(s) on the certifying statement.

This is a Medicare requirement. These notes must be from no more than 6 months prior to the shoes being fit and **MUST** be from the doctor! Notes from a PA, ARNP, etc. will not be acceptable to Medicare.

PLEASE RETURN ALL DOCUMENTATION TO THE PATIENT.

Thank you for your time and cooperation.

**Patient: Please call me at 386-252-2138 to schedule
an appointment once the documentation is complete.**

Sincerely,

Russell Dotson, C. L. Ped.
Dale's Shoes
453 South Nova Road

STATEMENT OF CERTIFYING PHYSICIAN for Therapeutic Shoes

I am writing to request you complete the Statement of Certifying Physician below for the patient listed so that we may provide them with therapeutic shoes and inserts. In order to qualify for Medicare reimbursement, your certification that they meet the conditions listed below is required. Per Medicare: It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed below is present. If requested by the supplier, you must provide copies of those records. (Robert D. Hoover, Jr., MD, MPH, FACP, Medicare Director, CIGNA, Jurisdiction C, February 2009).

Patient: _____ DOB: _____

- 1** This patient has diabetes mellitus: ☐ Type II ☐ Type I

(Diabetes ICD-10 Codes: E08.00 - E13.9)

- 2** This patient has one or more of the following conditions (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> a. History of partial or complete amputation of the foot | <input type="checkbox"/> d. Peripheral neuropathy with evidence of callus formation |
| <input type="checkbox"/> b. History of previous foot ulceration | <input type="checkbox"/> e. Foot deformity (can include: thickened and hard to trim toenails, ingrown toenails, corns, calluses, bunions, deformed or hammered toes) |
| <input type="checkbox"/> c. History of pre-ulcerative callus | <input type="checkbox"/> f. Poor circulation |

- 3** I am treating this patient under a comprehensive plan for care of his/her diabetes and the date of their last office visit during which we addressed their diabetes management was: _____.

- 4** This patient needs special shoes (depth or custom-molded) because of his/her diabetes.

- 5** This patient needs shoe inserts (heat-molded or custom fabricated) because of his/her diabetes.

Physician Signature: _____ Date: _____

Physician Name: _____ NPI #: _____

Physician Address: _____

DETAILED WRITTEN ORDER

Patient: _____

D.O.B.: _____

Date of Order: _____

HICN: _____

Quantity: (please check)	HCPCS Code:	Description:
<input type="checkbox"/> 1 Pair	A5500	Diabetic Depth Shoes, pair
<input type="checkbox"/> 3 Pair	A5512	Prefabricated inserts pairs-multiple density, direct formed, molded to foot with external heat source (i.e. heat gun). Medicare allows three pairs of inserts per year.
	OR	
<input type="checkbox"/> 3 Pair	A5513	Custom-molded inserts – multiple, density, molded to model of the patient's foot. Medicare allows up to three pairs of inserts per year.
<input type="checkbox"/> 1 Left Partial Foot Filler (L5000)		<input type="checkbox"/> 3 Right Custom Inserts
<input type="checkbox"/> 1 Right Partial Foot Filler (L5000)		<input type="checkbox"/> 3 Left Custom Inserts

Primary Diagnosis Code: _____

According to "Physician Notes on Qualifying Condition(s)"

Please confirm that the entered Diagnosis Code matches your charting documentation.

E08.00 - E08.9	Diabetes mellitus due to underlying condition
E09.00 - E09.9	Drug or chemical induced diabetes mellitus
E10.00 - E10.9	Type 1 diabetes mellitus
E11.00 - E11.9	Type 2 diabetes mellitus
E13.00 - E13.9	Other specified diabetes mellitus

Duration of usage: 12 Months

Prescriber Signature: _____
(Stamped signature not allowable)

Date: _____

Prescriber NPI #: _____

Prescriber Name: (printed) _____
Must be the MD, DO or other eligible prescriber who is actively treating patient's diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)

DIABETIC FOOT EXAM FOR THERAPEUTIC SHOES

Person to contact if questions: _____ Date of Evaluation: _____

Patient Name: _____ HICN #: _____

1 Diabetes Type:

☐ Type I, Controlled (1) ☐ Type II, Controlled (0) ☐ Type I, Uncontrolled (3) ☐ Type II, Uncontrolled (2)

2 Diabetes Management (Required to support discussion of diabetes management)

Plan of Care: ☐ Diet ☐ Oral Meds ☐ Injection ☐ Pump

Treatment Plan:

Start Date: _____ Duration of DM: _____ Date of Last FBS: _____

3 Physical Exam:

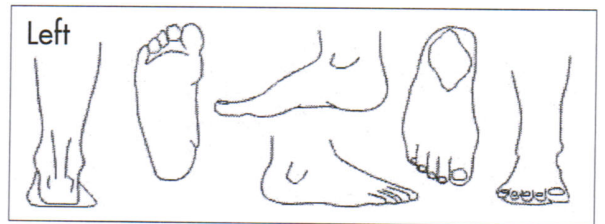
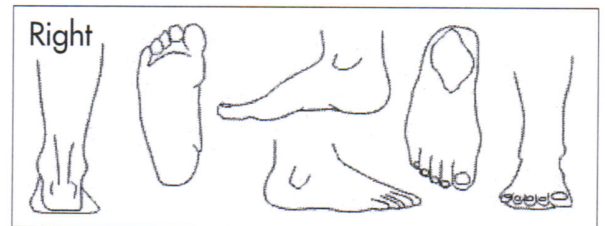
Neurological (use Y or N)	Right	Left
Loss of Vibration Perception		
Loss of Protective Sensation		

Vascular (circle appropriate level)	Right	Left
Dorsalis Pedis (3 = normal)	0 1 2 3 4	0 1 2 3 4
Posterior Tibial (3 = normal)	0 1 2 3 4	0 1 2 3 4

4 Physical Exam Part 2: Please refer to the findings when noting secondary risk factor(s) on "Statement of Certifying Physician"

Please Indicate any calluses, bunions, swelling, redness, deformities, amputation or wounds using the symbol key below:

Callus **C** Bunion **B** Swelling **S** Redness **R**
Deformity **D** Hammer/Claw Toe **HC**
Amputation **A** Wound **W**



5 Diagnosis Code: _____

6 Certifying Physician Acknowledgment*

I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and insoles.

Physician Signature: _____ Date: _____
(Stamped signature not allowable)

Physician Name: _____ Physician NPI #: _____
(printed)

***Please complete ALL steps as indicated.
As required by Medicare, save in patient's chart.**

**A COPY OF YOUR
PROGRESS NOTE(S)
DOCUMENTING THE
MANAGEMENT OF THE
PATIENT'S DIABETES IS
REQUIRED BY
MEDICARE. THE
PROGRESS NOTES MUST
BE SIGNED BY EITHER A
M.D. OR D.O.**

**MEDICARE WILL NOT
ACCEPT THE PROGRESS
NOTES OF A PA OR RN**