STATEMENT OF CERTIFYING PHYSICIAN for Therapeutic Shoes

THE Shoe GUYS
By Daily Living Medical

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: _____ **Medicare #:** _____

1) This patient has diabetes mellitus: ☐ Type II ☐ Type I (ICD-10 Code(s): _____)
2) This 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 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: _____
_____
_____

PLEASE FAX BACK TO:

Daily Living Medical
877-326-3285

Date:

Patient:

D.O.B.:

Re: Diabetic Footwear Documentation Request

Dear Dr.

Fax Number

I am writing to request your assistance in providing the above patient with diabetic footwear, as provided under the Therapeutic Shoes for Persons with Diabetes Act (TSPD). In order to qualify for Medicare reimbursement, your certification that they meet certain conditions is required, as well as a prescription for diabetic shoes and inserts. I am asking you to please review and complete the attached forms, as follows:

1) STATEMENT OF CERTIFYING PHYSICIAN

- *COMPLETE, SIGN AND DATE*
- Please check appropriate items, based on your diagnosis.

2) COPY OF YOUR PATIENT NOTES INDICATING:

1. **The patient has one of the six Qualifying Conditions listed on *The Statement of Certifying Physician*, AND**
2. **The date of last visit to discuss the management of the patient's diabetes**
   This is required by Medicare

3) PRESCRIPTION FOR DIABETIC SHOES AND INSERTS

- *COMPLETE, SIGN AND DATE*

4) FAX THESE BACK TO ME AT: 877-326-3285

Please do not hesitate to call me at 573-234-2005 if you have any questions.

I greatly appreciate your assistance in serving the needs of this patient.

Sincerely,

Jenn Clark, CPC
Office Administrator
Daily Living Medical

PRESCRIPTION for Diabetic Shoes and Inserts

Patient Name: _____ **Medicare ID #:** _____

Date of Birth: _____ **Today's Date:** _____

Check all that apply:

- ☐ Diabetes Mellitus
- ☐ Hammertoe(s)
- ☐ Bunion(s)
- ☐ Ulcer(s)
- ☐ Callus(es)
- ☐ Amputation(s)
- ☐ Charcot Deformity
- ☐ Fasciitis
- ☐ Edema
- ☐ Corn(s)
- ☐ Ankle Instability
- ☐ Drop Foot
- ☐ Posterior Tib. Disorder
- ☐ Peripheral Vascular Disease
- ☐ Neuropathy

The patient requires:

- ○ Diabetic Footwear, non-custom (A5500) – 1 pair (unless otherwise indicated)

With (select one):

- ○ Non-custom, heat moldable inserts (A5512) – 3 pairs (unless otherwise indicated)
- ○ Custom molded inserts (A5513) – 3 pairs (unless otherwise indicated)

  Lesions requiring offloading: L 1 2 3 4 5

  R 1 2 3 4 5

  - ○ Toe filler (L5000)

    Comments: _____

    _____

    _____

Clinician Name: _____

Signature: _____ **Date:** _____