

Patient Info

PATIENT NAME		DATE
PATIENT RECORD ID	PATIENT D.O.B.	PATIENT MCI#

Re: Diabetic Footwear Documentation Request

Dear Dr.

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) SSA 1861 (s)2. 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.

May I ask you to please review and complete the attached forms as follows:

Statement of Certifying Physician - complete, sign and date

Copy of your patient notes indicating:

a. Management of the Diabetes and last visit

Copy of your notes:

Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement;

- or -

Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/ inserts, and that documents one or more of criteria a – f.

Fax or email these back to us at:

Please do not hesitate to call me at if you have any questions. I greatly appreciate your assistance in serving the needs of this patient.

Sincerely,

Patient Info

PATIENT NAME		DATE OF BIRTH
PATIENT MCI#		

I hereby certify that the patient mentioned above:

1. Has Diabetes

Type I (ICD-10 Code(s):

Type II (ICD-10 Code(s):

2. This patient has 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 of care for his/her diabetes.

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

PHYSICIAN SIGNATURE		DATE
PHYSICIAN NAME		NPI#
PHYSICIAN ADDRESS		
CITY	STATE	ZIP CODE

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Examining Physician Signature: I have reviewed the above diagnosis and agree with the findings. I am including a copy of this diagnosis in the patient's file.

SIGNATURE:	
PRINT NAME:	DATE

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DATE OF BIRTH	TODAY'S DATE
PATIENT MCI#	

Check all that apply

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> DIABETES MELLITUS | <input type="checkbox"/> CALLUS(ES) | <input type="checkbox"/> CORN(S) | <input type="checkbox"/> ULCER(S) |
| <input type="checkbox"/> HAMMERTOE(S) | <input type="checkbox"/> AMPUTATION(S) | <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> BUNION(S) | <input type="checkbox"/> CHARCOT DEFORMITY | <input type="checkbox"/> NEUROPATHY | |

Others**THE PATIENT REQUIRES**

- THERAPEUTIC FOOTWEAR, NON-CUSTOM (A5500) - 1 PAIR (UNLESS OTHERWISE INDICATED) WITH (SELECT ONE OPTION FROM BELOW)
- NON-CUSTOM, HEAT MOLDABLE (A5512) 3 PAIRS (UNLESS OTHERWISE INDICATED)
- CUSTOM MOLDED INSERTS (A5513/A5514) - 3 PAIRS (UNLESS OTHERWISE INDICATED)
- LESIONS REQUIRING OFFLOADING L 1 2 3 4 5
- R 1 2 3 4 5
- TOE FILLER (L5000)
- INDICATE LEFT OR RIGHT FOOT L R

COMMENTS:

Prescriber's Name

SIGNATURE:	DATE
NPI# OF ORDERING ENTITY (M.D./D.O./DPM/PA/CNS/NP):	

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PATIENT MCI#	Met With Patient In-Person on (DATE):
AT THE FOLLOWING LOCATION :	

Comments

OBJECTIVE ASSESSMENT OF THE FEET :
DIAGNOSIS-SPECIFIC ISSUES FROM PRESCRIPTION TO BE CONSIDERED :

Patient Shoe Fitting Info

Authorization

I authorize Medicare and my supplemental insurance to pay directly, as I am satisfied with the fit of the shoes and inserts I received. I understand Medicare may reimburse for up to one pair of shoes (2 individual) and 3 pair of inserts (6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare and/or my co-insurance does not cover. I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.

Patient's Warranty Statement:Our office will accept returns of any Dr. Comfort® shoes, for any reason within thirty days of the shoes being dispensed. If, within thirty days, we determine the shoes do not fit properly, we will replace them at no extra charge with a properly fitted shoe. Dr. Comfort® shoes that have been dispensed for a period of over thirty days will only be exchanged or credited at our discretion. Any shoes that are returned must be returned in the original, unaltered shoe box.

Supplier Standards and Break-in Procedure:The Supplier has provided me with current, written copies of the Medicare DMEPOS Supplier Standards, and Footwear Instructions. The supplier has educated me on the proper break-in procedure for my Dr. Comfort® shoes. The Supplier has also provided me with a "complaint protocol" to resolve any further disputes regarding the products dispensed.

PATIENT SIGNATURE	DATE
WITNESS SIGNATURE	DATE

Need patients chart notes.