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 of more of criteria a – f.

Fax or email these back to us at:

Please do not hesitate to call me atif 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

Patient Info

PATIENT NAME	RECORD ID
PATIENT MCI#	

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

Patient Info

PATIENT NAME	RECORD ID#
DATE OF BIRTH	TODAY'S DATE
PATIENT MCI#	

Check all that apply

- ☐ DIABETES MELLITUS
- ☐ CALLUS(ES)
- ☐ CORN(S)
- ☐ ULCER(S)
- ☐ HAMMERTOE(S)
- ☐ AMPUTATION(S)
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ OTHER
- ☐ BUNION(S)
- ☐ CHARCOT DEFORMITY
- ☐ 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):	

Patient Info

PATIENT NAME	RECORD ID
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

DATE OF FITTING :		CURRENT SIZE & WIDTH :	
	RIGHT FOOT :	LEFT FOOT :	COMMENTS :
1. HEEL TO TOE			
2. HEEL TO BALL			
3. MIDPOINT OF 1 & 2			
4. WIDTH			
5. HIGH INSTEP / INTERNAL BRACE*	◯ YES / NO ◯	◯ YES / NO ◯	
6. ANKLE INSTABILITY**	◯ YES / NO ◯	◯ YES / NO ◯	
7. HAMMERTOES / BUNIONS***	◯ YES / NO ◯	◯ YES / NO ◯	

*CONSIDER THE BETTY, DOUGLAS, MAGGY X OR WILLIAM X **CONSIDER THE RANGER, VIGOR OR BOSS ***CONSIDER THE ANNIE, BRIAN OR MERRY JANE LYCRA

MIDPOINT MEASUREMENT IS THE SIZE THAT IS HALFWAY BETWEEN HEEL TO TOE AND HEEL TO BALL TO THE CLOSEST FULL OR HALF SIZE, BUT NEVER MORE THAN ONE FULL SIZE GREATER THAN HEEL TO TOE MEASUREMENT. USE THE MIDPOINT TO DETERMINE WIDTH SIZE. TRY A SHOE ON CLOSEST TO THIS MEASUREMENT (MIDPOINT AND WIDTH)

Name	Color	Size	Width

Pairs of Inserts

◯ 1 ◯ 2 ◯ 3

Fitter's Signature	Date **10-12-2020**

Patient Info

PATIENT NAME	RECORD ID
PATIENT MCI#	
Met With Patient In-Person on (DATE): **10-12-2020**	
AT THE FOLLOWING LOCATION :	
ITEMS BEING DISPENSED :	

Comments

SUPPLIER'S OBJECTIVE COMMENTS REGARDING FIT :	
SUPPLIER'S COMMENTS REGARDING FIT AND ANY ACCOMODATIONS MADE AT TIME OF DISPENSING :	
FOLLOW-UP INSTRUCTIONS TO PATIENT AND PLAN OF CARE NOTES :	
PRINT NAME :	Date

Patient Info

PATIENT NAME		RECORD ID
PATIENT MCI#		
DELIVER ADDRESS		
CITY	STATE	ZIP CODE

I have received (enter “2” for a pair) individual Dr. Comfort*
(Style: _____ Color: _____ SIZE _____ Width: _____)

extra depth shoes and (choose one below):

◯ _____ (enter *6* for 3 pairs) individual Dr. Comfort® full contact custom therapeutic inserts (A5513/A5514 PDAC compliant).

◯ _____ (enter *6* for 3 pairs) individual Dr. Comfort® therapeutic inserts (A5512 PDAC compliant).

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.

Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500)

Medication Transfer Sheet/Release of Responsibility

Name of Facility: _____

Name of Resident: _____

_____

Date of Release: Expected Date of Return:

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:

a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.

OR

b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR

c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: _____
Received by: _____ Date: _____ Time: _____
Signature of person returning unused medications: _____
Staff signature of count on return: _____ Date: _____ Time: _____