Diabetic Shoes and Inserts

Foot Solutions Phoenix
2340 West Bell Rd. Ste. 112
Phoenix AZ 85023

FOOT SOLUTIONS

Medical Support
Tel.: 845-200-6606
Fax: 914-618-4599
phoenix@footsolutions.com

Please refer to the request below for your patient's Medicare Diabetic Shoes Program

To: DR
Phone:
Fax:

From: Foot Solutions Phoenix Medical Support
Date:
Re:

Dear Dr.

You referred your patient (DOB:) for/or they have requested diabetic shoes and inserts.

Medicare law is very strict and requires physicians to provide the following documentation for their patients so that they can benefit from their diabetic shoes and inserts program.

All three steps must be completed:

1. *S TANDARD WRITTEN ORDER - Please check the type of shoes and inserts you want for your patient.*

   &

   STATEMENT OF CERTIFYING PHYSICIAN - If not checked already, check your patient's specific foot condition(s). Sign and date the Statement. Can only be signed by DR.

2. *NOTES ON QUALIFYING CONDITIONS – Check all foot condition(s) that your patient has and summarize findings under "enter comments" (attached). Can only be signed by DR.*

3. *PROGRESS / CHART / SOAP NOTES - Send DR. 's most recent office visit notes for the diabetic evaluation and diabetic foot exam. The visit must be within the last 6 months of today's date.*

   DR. must sign and date the notes.

   Notes for the diabetes evaluation must be by a MD or DO or by a NP or PA.

If the evaluation of the patient's diabetes condition is done by a PA, the supervising physician must ~~Verify & agree (sign and date) the PA notes to acknowledge agreement with the actions of the PA.~~

Therefore:

DR. must write "Verified & Agree" sign and date the first page of the PA medical notes.

Thank You!

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Standard Written Order

Order valid for 6 months from date of signature

Patient Name: DOB:

Physician MD/DO (Print): Date of Order :

I PRESCRIBING: (Please Circle)

- 1 Pair A5500 Depth Inlay Shoes
- 1 Pair A5501 Custom Depth Inlay Shoes
- 3 Pairs A5512 Heat Molded Multi-Density Inserts
- 3 Pairs A5513/A5514 Custom Fabricated Inserts
- Partial Foot Toe Filler Right Left
- Custom Inserts Other Foot
- Other (Describe) _____

I CERTIFY THAT I AM THE PRESCRIBING PHYSICIAN, I HAVE REVIEWED THIS DETAILED WRITTEN ORDER AND CONFIRM THE ITEMS PRESCRIBED AND DIAGNOSIS ARE TO THE BEST OF MY KNOWLEDGE ACCURATE.

Statement of Certifying Physician

Valid for 3 months from date of signature

The Statement of Certifying Physician may only be signed by a M.D.,D.O or NP AND by a PA practicing "incident to" the supervision of an MD or DO

Patient Name: DOB:

Physician MD/DO: _____ NPI: _____

Physician Address: _____

Phone: _____ Fax: _____

I certify all of the following statements are true: (Please circle)

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions: (Check all that apply)

- History of partial or complete amputation of the foot
- Peripheral neuropathy with evidence of callus formation
- History of previous foot ulceration
- Foot Deformity
- History of pre-ulcerative callus
- 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:

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Notes on Qualifying Conditions for Diabetic Shoes & Inserts

Per Medicare law, the foot condition(s) must be noted here or in the Medical Notes

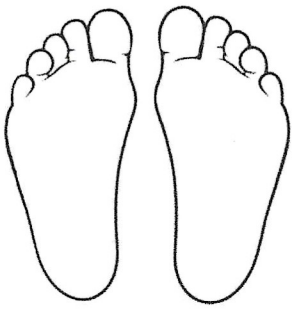
Foot Exam Conducted By: NPI:

Patient Name: DOB:
Address:
Phone: Email: HICN:

Findings of the Foot Exam : *Please check all condition(s) that apply to your patient.*

Conditions	Left	Right
Neuropathy / Absent-Decreased Sensation (monofilament exam)		
History of Previous Foot Ulceration		
Callus		
History of Pre-ulcerative Callus		
Hammertoe(s)		
Bunion(s)		
Other Foot / Toe Deformities (Described in summary below)		
Charcot Joint		
Charcot Marie-Tooth		
Diminished Dorsalis / Pedal Pulses		
Vascular Disease / Absent-Decreased Circulation – Lower Extremities		
Toe / Foot Amputation(s) (Described in summary below)		

Note Location of: Callus (C), Pre-ulceration / Ulcers (U), Diminished Sensation (+/-), Diminished Pulses (+1, +2)



The notes below summarize the findings of my patient's foot exam.

PHYSICIAN SIGNATURE: DATE: