Therapeutic Shoes and Inserts

Foot Solutions Greenville
108 E. Butler Road Ste. K
Greenville SC 29662

TSB Medical Compliance
Tel.: 602-689-9363
Fax: 602-354-9298
Email: medical@tsbbilling.com

Paperwork for your patient's Medicare Diabetic Shoes Program

Medicare requires the physician to be managing the patient's diabetes under a comprehensive plan of care

To:	Dr.	From:	TSB Medical Compliance for Foot Solutions
Phone:		Date:	
Fax:		Re:	

Dear **Dr.** ,

Medicare needs the following paperwork from you to provide diabetic shoes and orthotics for your patient:

(DOB:)

- *STANDARD WRITTEN ORDER & STATEMENT OF CERTIFYING PHYSICIAN – Complete the form by checking the type of shoes & inserts the patient needs. Also, check your patient's specific foot condition(s) if not already checked.* ***Please sign and date both forms.*** *Refer to the arrows indicating the required signature locations.*

- *NOTES ON QUALIFYING CONDITIONS – Check all foot condition(s) that your patient has and summarize findings under "enter comments"* ***Please sign and date it.***

- *MEDICAL NOTES – Include most recent* ***PROGRESS NOTES FOR 's DIABETES EVALUATION.*** *These must be within the last 6 months of today's date and* ***must be signed by the provider.***
  - *IF the DM evaluation notes is by a* ***NP or PA****, Medicare requires* ***DR.*** *verify & agree" by signing and dating the first page of the* ***NP or PA*** *medical notes to acknowledge agreement with their actions.*

PLEASE REMEMBER THE CHART NOTES

If you have any questions, call TSB Medical Compliance at 602-689-9363.

PLEASE FAX BACK TO 1-602-354-9298 Thank You!

We appreciate your assistance and timely attention to this request.

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Standard Written Order

Order valid for 6 months from date of signature

Patient Name (Print): DOB:

Provider Name (Print): NPI:

I Am Prescribing: Date of Order: _____

- ☐ 1 Pair A5500 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 standard written order and confirm the items prescribed and diagnosis are to the best of my knowledge accurate.

PHYSICIAN SIGNATURE: _____ DATE: _____

Statement of Certifying Physician

Valid for 3 months from date of signature

Patient Name (Print): DOB:

Physician MD/DO: ..... NPI: .....

Physician Address: .....

Phone: ..... Fax: .....

I certify all of the following statements are true:

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
- ☐ 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: .....

The Statement of Certifying Physician may only be signed by a M.D., D.O., NP or PA

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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:

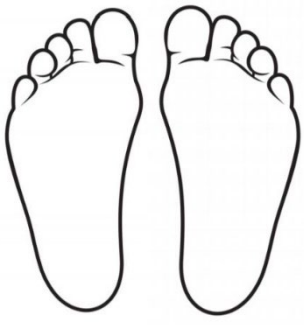
Patient Name: ..... DOB: ..... Phone: .....

Address: ..... DOS: .....

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: .....