

# 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.

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

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- **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

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: .....

*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: \_\_\_\_\_