DALE'S SHOES AND PEDORTHICS
Phone: 386-252-2138
2595 W. International Speedway Blvd. (US 92)
Daytona Beach, FL 32114
Fax: 386-252-0928

dale's shoes and pedorthics
dalesshoes.com

Customer Info:

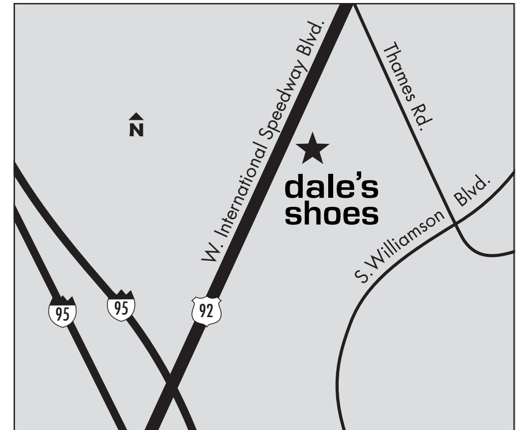
Date: ______________________________

Patient: ______________________________

D.O.B.: ______________________________

Re: Diabetic Footwear Documentation Request

Dear ______________________________



We must have this paper work in order for your patient to qualify for the therapeutic shoe benefit...or MEDICARE WILL DENY THEIR CLAIM!

1. Fill out the statement of certifying physician. This MUST be completed and signed by the MD or DO managing the patient's diabetic condition.
2. Fill out the detailed written order.
3. Complete the foot evaluation and supply us with a copy of the latest office visit note documenting an in-person meeting with the doctor and that the patient is being treated under a comprehensive plan of care for their diabetes.

OR A copy of the most recent office visit note as above that also documents the qualifying condition(s) on the certifying statement.

This is a Medicare requirement. These notes must be from no more than 6 months prior to the shoes being fit and MUST be from the doctor! Notes from a PA, ARNP, etc. will not be acceptable to Medicare.

PLEASE RETURN ALL DOCUMENTATION TO THE PATIENT.

Thank you for your time and cooperation.

Patient: Please call me at 386-252-2138 to schedule an appointment once the documentation is complete.

Sincerely,

Russell Dotson, C. L. Ped.
Dale's Shoes
2595 W. Int'l Speedway Blvd.

STATEMENT OF CERTIFYING PHYSICIAN
for Therapeutic Shoes

I am writing to request you complete the Statement of Certifying Physician below for the patient listed so that we may provide them with therapeutic shoes and inserts. In order to qualify for Medicare reimbursement, your certification that they meet the conditions listed below is required. Per Medicare:

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed below is present. If requested by the supplier, you must provide copies of those records. (Robert D. Hoover, Jr., MD, MPH, FACP, Medicare Director, CIGNA, Jusrisdiction C, February 2009).

Patient:____ DOB: __________________

1 This patient has diabetes mellitus: ☐ Type II ☐ Type I

(Diabetes ICD-9 Codes: E08.00 - E13.9)

2 This patient has one or more of the following conditions (check all that apply):

☐ a. History of partial or complete amputation of the foot

☐ b. History of previous foot ulceration

☐ c. History of pre-ulcerative callus

☐ d. Peripheral neuropathy with evidence of callus formation

☐ e. Foot deformity (can include: thickened and hard to trim toenails, ingrown toenails, corns, calluses, bunions, deformed or hammered toes)

☐ f. Poor circulation

3 I am treating this patient under a comprehensive plan for care of his/her diabetes and the date of their last office visit during which we addressed theirdiabetes management was: _______________.

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

5 This patient needs shoe inserts (heat-molded or custom fabricated) because of his/her diabetes.

Physician Signature: ____________________________ Date:___________________

Physician Name: _______________________________ NPI #:_________________

Physician Address: ____

DETAILED WRITTEN ORDER

Patient:________________________________ D.O.B.: ______________

Date of Order: __________________________ HICN: ______________

Quantity: (please check)	HCPCS Code:	Description:
☐ 1 Pair	A5500	Diabetic Depth Shoes, pair
☐ 3 Pair	A5512	Prefabricated inserts pairs-multiple density, direct formed, molded to foot with external heat source (i.e. heat gun). Medicare allows three pairs of inserts per year.
	OR	
☐ 3 Pair	A5513	Custom-molded inserts – multiple, density, molded to model of the patient's foot. Medicare allows up to three pairs of inserts per year.

☐ 1 Left Partial Foot Filler (L5000) ☐ 3 Right Custom Inserts

☐ 1 Right Partial Foot Filler (L5000) ☐ 3 Left Custom Inserts

Primary Diagnosis Code: ___ ___ ___ ___ ___
According to "Physician Notes on Qualifying Condition(s)

Please confirm that the entered Diagnosis Code matches your charting documentation.

E08.00 - E08.9	Diabetes mellitus due to underlying condition
E09.00 - E09.9	Drug or chemical induced diabetes mellitus
E10.00 - E10.9	Type 1 diabetes mellitus
E11.00 - E11.9	Type 2 diabetes mellitus
E13.00 - E13.9	Other specified diabetes mellitus

Duration of usage: 12 Months

Prescriber Signature:__________________________ Date: ______________
(Stamped signature not allowable)

Prescriber NPI #:
____

Prescriber Name: (printed) ______________________
Must be the MD, DO or other eligible prescriber who is actively treating patient's diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)

DIABETIC FOOT EXAM FOR THERAPEUTIC SHOES

Person to contact if questions: ______________________ Date of Evaluation: ____________

Patient Name: ______________________________ HICN #: ______________

1 Diabetes Type:

☐ Type I, Controlled **(1)** ☐ Type II, Controlled **(0)** ☐ Type I, Uncontrolled **(3)** ☐ Type II, Uncontrolled **(2)**

2 Diabetes Management (Required to support discussion of diabetes management)

Plan of Care: ☐ Diet ☐ Oral Meds ☐ Injection ☐ Pump

Treatment Plan:

Start Date: ____________ Duration of DM: ___________ Date of Last FBS: ____________

3 Physical Exam:

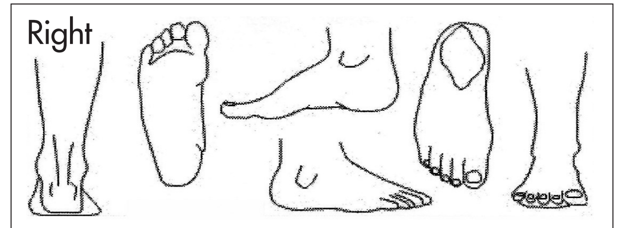
Neurological (use Y or N)	**Right**	**Left**
Loss of Vibration Perception		
Loss of Protective Sensation		

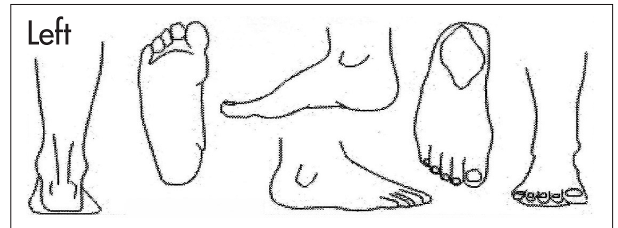
Vascular (circle appropriate level)	**Right**	**Left**
Dorsalis Pedis (3 = normal)	0 1 2 3 4	0 1 2 3 4
Posterior Tibial (3 = normal)	0 1 2 3 4	0 1 2 3 4

4 Physical Exam Part 2: Please refer to the findings when noting secondary risk factor(s) on "Statement of Certifying Physician"

Please Indicate any calluses, bunions, swelling, redness, deformities, amputation or wounds using the symbol key below:

Callus **C** Bunion **B** Swelling **S** Redness **R**
Deformity **D** Hammer/Claw Toe **HC**
Amputation **A** Wound **W**





5 Diagnosis Code: ___ ___ ___ ___ ___

6 Certifying Physician Acknowledgment*

I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and insoles.

Physician Signature: ______________________________ Date: ________________
(Stamped signature not allowable)

Physician Name: ______________________________ Physician NPI #: ____________
(printed)

***Please complete ALL steps as indicated.**
As required by Medicare, save in patient's chart.