STATEMENT OF CERTIFYING PHYSICIAN for Therapeutic Shoes

On behalf of this patient we are writing to request your completion of 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, Jurisdiction C, February 2009)

Patient: _____ D.O.B.: _____

⇨ 1) This patient has diabetes mellitus: ☐ Type II ☐ Type I (ICD-10 Code(s): _____)
(Diabetes ICD-10 Codes: E10.9 E10.10 E10.65 E11.9 E11.65)

⇨ 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
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Foot deformity
- ☐ 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 their diabetes 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: _____
_____
_____

PLEASE FAX TO Mobility & More: 704-821-7777

EXAMINING PHYSICIAN DIAGNOSIS of Qualifying Condition

Patient Name: _____

D.O.B: _____

Examining Physician is currently treating the above patient and has made the diagnosis below as part of an examination of the patient. Based on the patient's diabetes and qualifying condition, Examining Physician is recommending diabetic footwear.

Excerpt from Patient Notes Including Diagnosis of Qualifying Condition

⇨ Paste Your Diagnosis Notes Here and Sign Below. You may also write "see attached" and fax your patient diagnosis notes on a separate page.

TIP: Keep your notes brief and avoid extraneous information. Include your diagnosis and description of the qualifying condition and state that your treatment plan includes diabetic shoes and inserts.

⇨ **EXAMINING PHYSICIAN SIGNATURE**

Signature: _____

Print Name: _____

Date: _____

⇨ **PRIMARY CARE PHYSICIAN ACKNOWLEDGMENT**

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: _____

PLEASE FAX TO Mobility & More: 704-821-7777

PRESCRIPTION for Diabetic Shoes and Inserts

Patient Name: _____

D.O.B. _____

⇨ Per Statement of the Certifying Physician, the patient has one or more of the following foot conditions:

___ Previous Amputation ___ Peripheral Neuropathy ___ Previous Ulceration

___ Foot Deformity ___ Pre Ulcerative Callus ___ Poor Circulation

___ Peripheral Neuropathy with evidence of callus formation

Type of Shoe Prescribed: ___ Extra-Depth (A5500) ___ Custom Molded (A5501)

Number of Pairs: _____

Type of Inserts Prescribed: ___ Heat-Moldable (A5512) ___ Custom Fabricated (A5513)

Number of Pairs: _____

⇨ **Additional Instructions or Modifications:** _____

_____

_____

_____

_____

⇨ Prescribing Physician's Signature _____

⇨ Prescribing Physician's Name (Printed) _____

⇨ Date Signed _____

PLEASE FAX TO Mobility & More: 704-821-7777