PRESCRIPTION FOR THERAPEUTIC SHOES AND INSERTS

Patient Name: _____

MBI#: _____ DOB: _____

Quantity:	HCPCS Code:	Description:
☐ *1*	A5500	Diabetic Extra-Depth Shoes, pair
☐ *3* ☐ *2* ☐ *1*	A5512	Prefabricated Heat Moldable Inserts, pair
☐ *3* ☐ *2* ☐ *1*	A5514	Custom Fabricated Inserts, pair

1 Anodyne Partial Foot Filler (L5000) – ☐ *L* ☐ *R* ☐ *BL*

3 Anodyne Custom Fabricated Inserts (A5514) – ☐ *L* ☐ *R*

Other: _____

_____

Diagnosis: Diabetes Mellitus and _____

_____ (qualifying foot conditions).

Therapeutic Objectives:

☐ *Prevent ulceration and other pedal complications*

☐ *Distribute weight, balance and plantar pressure*

Duration of usage: 12 Months

Physician Signature: _____ Date: _____

Physician Name (printed): _____ NPI: _____

Physician Address: _____

Please ensure this form is completed by the **DPM, MD, DO, PA, NP or CNS that performed the patient's Foot Exam. No stamped signatures permitted.*

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES AND INSERTS

Patient Name: _____

MBI#: _____ DOB: _____

Please complete this Statement of Certifying Physician for the patient listed above so that we may provide them with therapeutic shoes and inserts.

To qualify for Medicare reimbursement, it is required that the Primary Care Physician certify that the patient meets one or more of the conditions listed below.

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions (indicate 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*

   Please make certain these condition(s) are consistent with and supported by clinical findings noted in the patient's Diabetes Management Exam Notes and/or Foot Exam.
3. I am treating this patient under a comprehensive plan of care for diabetes.
4. This patient needs special shoes and inserts to help prevent complications resulting from diabetes.

Physician Signature: _____ Date: _____

Physician Name (printed): _____ NPI: _____

Physician Address: _____

Please ensure this form is completed by the **MD or DO only. No stamped signatures permitted.*

DEAR DOCTOR,

I recently received a preliminary diabetic foot evaluation which indicated that I have a significant risk of developing diabetes related foot complications and may qualify for footwear and inserts under the Medicare Therapeutic Shoe Bill.

To qualify for Medicare reimbursement, a patient's Primary Care Physician (MD or DO) is required to certify that the patient meets one or more of the qualifying conditions listed on the Statement of Certifying Physician (included).

To satisfy this requirement, I ask that you please send or provide my most recent Diabetes Management Exam Notes **(1)** and complete and return the attached forms **(2 and 3):**

1. **Diabetes Management Exam Note**
   - *Signed and dated by **MD or DO only.***
   - *Within last 6 months; Signed and Dated.*
   - *Foot findings must support items checked on the Statement of Certifying Physician.*
2. **Statement of Certifying Physician**
   - *Complete, Sign, and Date by **MD or DO only.***
3. **Prescription for Diabetic Shoes and Inserts**
   - *Complete, Sign, and Date by **DPM, MD, DO, PA, NP or CNS** who performed the Foot Exam.*

If you cannot immediately provide these documents to me immediately, please fax them to:

Supplier Contact Info