Carl's Shoes

Where Shoes Are Fitted, *Not Just Sold.*

Certified Pedorthic Facility & Professional Orthotics

Medicare Diabetic Shoes

PLEASE READ CAREFULLY

Medicare coverage provides one pair of diabetic shoes and three sets of diabetic shoe inlays per calendar year as medically necessary. *Medicare usually covers 80% of the bill. SOME secondary insurance companies may cover part or all of the remaining 20%.* With a prescription, we also accept Aetna, Amerihealth, Blue Cross/Blue Shield, Independence Blue Cross, Horizon New Jersey Health, and Keystone.

Please follow the instructions below to have the cost of your shoes/inlays/modifications POSSIBLY covered by Medicare. Failure to follow the instructions will cause Medicare to deny your claim.

BEFORE YOU COME IN TO BE FITTED

1. Go to the physician treating your diabetes and have your feet examined. You must have had an office visit with the physician that treats your diabetes within six months prior to your shoe fitting. The form will expire three months from the date the physician signs it.
2. Have the physician complete the entire certification form for your diabetic shoes/inlays/modifications.
3. The physician must include a copy of the medical records that were used to complete this form.

PLEASE BRING THE FOLLOWING TO CARL'S SHOES

1. Your completed **Statement of Certifying Physician for Therapeutic Shoes** form and **Prescription for Therapeutic Footwear** form. The form will expire three months from the date of the physician's signature.
2. All of your insurance cards.
3. Photo ID.
4. A copy of your doctor's medical notes from your last office visit that pertain to your diabetic footwear.

If you do not have all of the above information completed prior to your visit to Carl's Shoes, we will not be able to process your prescription. If you have any questions, please feel free to call us at 856.235.6223.

Thank you,

Carl's Shoes

27 West Main St., Moorestown, NJ 08057
phone **856.235.6223** | *fax* **866.445.4067** | **CarlsShoes.com**

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Statement of Certifying Physician for Therapeutic Shoes

Patient Name _____ Policy # _____

Patient Telephone _____ Date of Birth _____

This section to be completed by physician treating Diabetes. Must be MD or DO.
Please include records used to complete this form.

I certify that all the following statements are true and are documented in the patient's medical records:

1. This patient has Diabetes Mellitus. ICD-**10** CODE _____
2. Date of the patient's most recent office visit _____
3. This patient has one or more of the following conditions that have been documented in their medical records within the last six months (Check all that apply):
   - __ History of partial or complete amputation of the foot
   - __ History of pre-ulcerative callus on either foot
   - __ Peripheral neuropathy with evidence of callus formation on either foot
   - __ History of previous foot ulceration
   - __ Foot deformity of either foot
   - __ Poor circulation of either foot
4. I am treating this patient under a comprehensive plan of care for his/her diabetes. Yes___ No___
5. Patient needs special shoes (depth or custom molded) and/or inserts due to his/her diabetes. Yes___ No___

PHYSICIAN SIGNATURE Must be MD or DO. Original signature only. No signature stamp.

Signature _____ Date _____

(Please print)

Physician Name _____

Practice Name _____

Street _____

City _____ State _____ ZIP _____

Phone # _____ Fax # _____ NPI # _____

Prescription for Therapeutic Footwear

This section to be completed by MD, DO or DPM.
Items must be fitted within three months of physician's signature or this Rx will be considered VOID.

Rx Please dispense the following (Check one only):

- __ One Pair of Extra Depth Diabetic Shoes/ Three Pairs of Diabetic Inlays
- __ One Pair of Extra Depth Diabetic Shoes/ Three Pairs of Custom Molded Inlays
- __ One Pair of Custom Molded Diabetic Shoes/ Two Extra Pairs of Custom Molded Inlays
- __ Amputation Toe Filler/Foot Filler Right ___ Left ___
- __ Other (Please explain)

Duration of use: 12 months. ICD-**10** CODE to justify the need for the items being prescribed.

_____

PHYSICIAN SIGNATURE Must be MD or DO. Original signature only. No signature stamp.

Signature _____ Date _____

(Please print)

Physician Name _____

Practice Name _____

Street _____

City _____ State _____ ZIP _____

Phone # _____ Fax # _____ NPI # _____