Carl's Shoes

***Where Shoes Are Fitted,*** *Not Just Sold.*

**Certified Pedorthic Facility & Professional Orthotics**

# Medicare Diabetic Shoes

**Attached is a Statement of Certifying Physician Form for diabetic shoes. The top half of the form should be completed by the doctor that treats the diabetes. The bottom half of the form should be completed by the doctor that does a diabetic foot exam. The form is valid for 3 months from the date next to the doctor's signature. In addition to the completed form, photo ID and insurance cards, you must also bring in the following documentation from your doctor(s):**

**From the doctor that filled out the top portion of your form (must be the doctor that treats your diabetes):**

Chart notes from your last office visit within the last 6 months which show documentation of the following:

- The management/treatment of your diabetes (including an ICD-10 code)
- Documentation of the conditions that the doctor checked off in statement #3 of the form. If the doctor is receiving information on those conditions from another doctor, they must state that in their chart notes and that they agree with the other doctor's findings.
- Chart notes must be signed or electronically signed by the MD or DO that completed the form. If a Nurse Practitioner or Physician Assistant completed the chart notes, the MD or DO that completed the form must write a statement that they agree with the APN or PA findings and plan of care.

**From the doctor that filled out the bottom portion of your form or wrote the prescription (Rx) (Must be the doctor that does a diabetic foot exam.):**

- Documentation that a diabetic foot exam was performed within the last 6 months
- The ICD-10 code to justify the need for diabetic shoes
- Chart notes must be signed or electronically signed by the MD, DO or DPM that completed the bottom half of the form and/or wrote the Rx.

You are responsible for obtaining this information from your doctor(s). **It is a Medicare requirement that we have it on file.** Once you bring in this documentation and it has been checked for the information that Medicare requires, you can be fitted for your items. Please come in on a Monday, Tuesday, Thursday or Saturday between 10:00am-3:00pm.

We look forward to seeing you!

**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 # _____

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## 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, DO or DPM. Original signature only. No signature stamp.

Signature _____ Date _____

(Please print)

Physician Name _____

Practice Name _____

Street _____

City _____ State _____ ZIP _____

Phone # _____ Fax # _____ NPI # _____