



Where Shoes Are Fitted, Not Just Sold.®

Certified Pedorthic Facility & Professional Orthotics

Step-By-Step Medicare Paperwork Instructions

TOP HALF OF THE FORM

1. Make sure the patient's name and phone number are on the top. This will let us know who to contact if the form is faxed or mailed to us.
2. This portion can only be completed by an MD or DO who treats the patient's diabetes.
3. Make sure all questions (#1-5) are answered along with the doctor's signature, date, and all contact information. Medicare will only accept an MD or DO signature and will not accept a signature stamp.
4. The date you sign the form must be within 3 months of the patient being fit for their shoes and cannot be before the date in question #2.
5. Provide us a copy of the chart notes from the date of the patient's last diabetic visit. The notes must be the same date as listed on the form in question #2. The visit can be no more than 6 months old. **It is a Medicare requirement for these to be on file when we bill the claim.**
6. Be sure that the chart notes contain the patient's diabetic ICD-10 code that is stated in question #1 on the form.
7. Be sure that whichever condition is marked on question #3 is also stated in your chart notes. *If your notes don't contain one of the six conditions, Medicare will accept a signature stating you agree with the podiatrist's foot exam and findings.

BOTTOM HALF OF THE FORM

1. This portion can only be completed by the doctor who does the patient's foot exam. This can be an MD, DO, or DPM. According to Medicare, a foot exam must include results of a pedal pulse exam and a monofilament test.
2. Make sure you mark off what you would like us to dispense. This is the same thing as a prescription.
3. Make sure the doctor completes entire bottom half of the form including signature, date and all contact information. Medicare will only accept an MD, DO, or DPM signature and will not accept a signature stamp.
4. The date you sign the form must be within 3 months of the patient being fit for their shoes.
5. Provide us a copy of your chart notes showing the diabetic foot exam. This visit can be no more than 6 months old. **It is a Medicare requirement for these to be on file when we bill the claim.** According to Medicare, a foot exam must include results of a pedal pulse exam and a monofilament test.



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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):
4. I am treating this patient under a comprehensive plan of care for his/her diabetes.
5. Patient needs special shoes (depth or custom molded) and/or inserts due to his/her diabetes.

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

Signature Date
(Please print) Physician Name
Practice Name
Street
City State ZIP
Phone # Fax # NPI #