Happy New Year! Enclosed is a Statement of Certifying Physician form for diabetic shoes and inserts along with the directions for your doctor(s).

Once per calendar year and with the proper documentation from your doctor(s), Medicare may cover 80% of the cost of diabetic shoes and inserts. Some secondary insurances may cover part or all of the remaining balance. Please keep in mind that these items are not free. You may have a co-pay or balance that you are responsible for paying at the time of service.

Please read and follow the directions that we have enclosed with the form. It is your responsibility to make sure that you bring in the proper documentation that is required when you come in for your fitting. If your doctor faxes the information to us, please check with us ahead of your visit to make sure that we received it and it has been reviewed.

Along with the Medicare required documentation, you must bring in your photo ID and all of your insurance cards. You must call us to schedule an appointment for your fitting.

Let us help you make the paperwork easy. You can come into our store and sign a Medical Records Release Form, which we will fax to your doctor(s) with the Statement of Certifying Physician Form. You must provide us your doctor's fax number, as well as follow up with their office as to the status of your paperwork.

If you have any questions, feel free to call us at 856-235-6223. Thank you for your business and we look forward to seeing you in the near future.

Sincerely,

Jeffrey Higman, MBA, MS, MSIS, C.Ped, BOCPD, COF, CDME
President
jhigman@carlsshoes.com

MEDICARE PAPERWORK STEP-BY-STEP DIRECTIONS

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 is to be completed by the practitioner 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 not accept signature stamps.
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. 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 the entire bottom half of the form including signature, date and all contact information. Medicare will not accept signature stamps.
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.

Where Shoes Are Fitted, Not Just Sold.
Certified Pedorthic Facility & Professional Orthotics

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.
____
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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 #______________