THERAPEUTIC FOOTWEAR ORDER FORM

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Last updated: Mar17

On behalf of your patient named below, we are requesting your completion of this Statement of Certifying Physician so that we (the DMEPOS Supplier) may provide them with therapeutic shoes and inserts. In order to qualify for Medicare reimbursement, your certification that they meet the conditions listed below is required. Per Medicare guidelines (excerpt bolded below from Cigna Government Services), in the event of an audit for this particular patient's claim for therapeutic shoes and inserts:

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed below is present. When requested by the supplier, you must provide copies of those records. If you would not be able to meet such a request, please contact us prior to completing this form. We greatly appreciate your assistance in providing for this patient!

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

The patient above has diabetes mellitus (ICD-10 Code) _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

STATEMENT OF CERTIFYING PHYSICIAN

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS, FACE NOTES, INSURANCE NAME AND MEMBER ID NUMBER

I certify that the following statements are true: This patient is being treated under a comprehensive plan of care for diabetes. This patient will benefit from therapeutic shoes (depth or custom molded shoes) to assist in the treatment of his/her diabetes.

The patient has one or more of the following. (Please check all that apply)

- ☐ History of partial or complete amputation of either foot
- ☐ Peripheral Neuropathy with evidence of callus formation of either foot
- ☐ History of previous foot ulceration
- ☐ Foot deformity of either foot (bunions, hammer toes, etc.)
- ☐ History of pre-ulcerative callus formation
- ☐ Poor circulation in either foot

By signing below, I state that:

1. I am or was this patients treating physician for diabetic mellitus on the effective date of this order.
2. This order accurately reflects this patient's diagnosis and condition.
3. The patient's diagnosis, condition and the ordering of diabetic shoes and inserts are substantiated in my medical records.
(Please Fax These Records With This Order)
4. This order is part of my course of treatment and is "reasonably and medically necessary".
5. To my knowledge, the above information is accurate.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. PLEASE NOTE: the Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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