Dear Patient,

In order for us to schedule an evaluation appointment for diabetic shoes and inserts for Medicare patients, you will need to carry in all of the required documentation from the physician treating you for your overall diabetic condition. In order for Medicare to pay for your diabetic shoes and inserts, we must have the following documentation from your physician, not your podiatrist. We will evaluate the paperwork and let you know if it fulfills the Medicare requirements. We cannot accept fax documentation.

1) Prescription from your physician treating you for your overall diabetic condition (not your Podiatrist) within the last 6 months.

2) Certificate of Medical Necessity completed by the physician treating you for your diabetic condition within the last 3 months. The physician must certify that you have diabetes mellitus (Diagnosis codes 249.00-250.93), and one or more of the qualifying conditions listed below, and that you are in need of diabetic shoes and inserts.
   a. Previous amputation of other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy with evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation

3) Medical Records from the physician treating you for your diabetic condition from an in-person visit within 6 months.
   The physician's medical records must include the following (in addition to the CMN):
   1. Must state that the patient was seen “in-person”
   2. Must state that the patient has diabetes mellitus
   3. Must state the and describe the patients qualifying condition (a-f)
   4. Must state there is a “need for diabetic shoes and inserts”
   5. Must state that you are “treating the patient for their comprehensive plan of care for diabetes”
   6. Must be dated within the last 3 months.

4) A Diabetic Shoe and Insert Evaluation Form completed by the physician managing your overall diabetic condition.

Once you bring in all of the required documentation to our office, and our office determines that it meets Medicare requirements, we will call you to schedule an evaluation appointment.

5) An advanced beneficiary notice (ABN) will also need to be signed in our office before we can proceed with your order.

Thank You,
Nobbe Orthopedics, Inc.
Dear Physician,

In order for Medicare to provide coverage for diabetic shoes and inserts, the following information must be completed by you and received in our office. We have provided you with blank forms with no supplier information to maintain Medicare compliance.

1) Prescription from physician treating the patient for their overall diabetic condition (not a Podiatrist) within the last 6 months.

2) Certificate of Medical Necessity (CMN) completed by the physician treating the patient for their diabetic condition within the last 3 months. The physician must certify that the patient has diabetes mellitus (Diagnosis codes 249.00-250.93), and one or more of the qualifying conditions listed below, and that there is a need for diabetic shoes and inserts.
   a. Previous amputation of other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy with evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation

3) Medical Records from the physician treating the patient for his/her diabetic condition from an in-person visit within the last 6 months.

The physician’s medical records must include the following (in addition to the CMN):

1. Must state that the patient was seen “in-person”
2. Must state that the patient has diabetes mellitus
3. Must state and describe the patient’s qualifying condition (a-f)
4. Must state there is a “need for diabetic shoes and inserts”
5. Must state that you are “treating the patient for their comprehensive plan of care for diabetes”
6. Must be dated within the last 3 months.

4) A Diabetic Shoe and Insert Evaluation Form completed by the physician managing the patient for their overall diabetic condition.

In order for us to schedule an evaluation appointment for diabetic shoes and inserts for your patient, we will need all of the required documentation from the physician treating the patient for their overall diabetic condition, not a podiatrist.

Please provide the required documentation to your patient for him/her to carry in to our office for review. We will not accept this information via fax and MUST have the original documents. All forms MUST have original signatures for Medicare compliance.

Thank You for your assistance.
Nobbe Orthopedics, Inc.
DIABETIC FOOTWEAR PRESCRIPTION FORM

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM – THIS PRESCRIPTION MUST BE ACCOMPANIED BY A SIGNED STATEMENT OF CERTIFYING PHYSICIAN (SCP). THE SCP MUST BE SIGNED BY THE MD OR DO MANAGING THE PATIENT’S SYSTEMIC DIABETIC CONDITION.

Patient’s Name: ___________________ Date of Birth: __________________

Diabetic Dx ICD-9 code: ______ ______ ______ ______ 249.00–250.93 please include 2-digit ending

Patient must have at least ONE of the following (CHECK ALL THAT APPLY)

- Amputation of toe(s) (895.0)
- Ulcer of heel and midfoot (707.14)
- Ulcer other part of foot, toes (707.15)
- History of pre-ulcerative callus (707.9)
- Charcot Arthropathy (713.5)
- Deformity of toe(s), acquired (735.9)
- Polynuropathy in diabetes (357.2) AND history of pre-ulcerative callus (707.9)
- Atherosclerosis of ankle and foot, acquired (736.70)
- Atherosclerosis of extremity, unspecified (440.20)
- Atherosclerosis of extremity with intermittent claudication (440.21)
- Atherosclerosis of the extremity with ulceration (440.23)
- Peripheral vascular disease, unspecified (443.9)

Covered Shoes, Inserts and Modification (CHECK ALL ITEMS THAT YOU ARE PRESCRIBING FOR THIS PATIENT)

- SHOES, Extra Depth, Custom Made (A5501) AND 2 pair of custom fabricated inserts (A5513)
- SHOES, Extra Depth, Off-The-Shelf (A5500) – must include inserts – indicate inserts below

- INSERT, Prefabricated, Heat-Moldable* (A5512) please select quantity: 3 pair 2 pair 1 pair
- INSERT, Custom Fabricated (A5513) please select quantity: 3 pair 2 pair 1 pair
- INSERT, Custom Partial Foot Toe Filler (L5000) please select which foot: LEFT RIGHT

*Prefabricated inserts have an average life of 4 months. For 12 months of protection, patients should receive no less than 3 pair of prefabricated inserts per year. Medicare allows up to 3 pair of inserts per year.

**Modifications to a shoe listed below MUST be a substitute for an insert**

- Rigid Rocker Bottom Sole (A5503)
- Wedge, Sole and/or Heel (A5504)
- Metatarsal Bar (A5505)
- Off-Set heel(s) (A5506)
- Other (medial/lateral stabilizer, flare, etc) (A5507)

PRESCRIBING PHYSICIAN INFORMATION:

__________________________________________________  __________________________________________________

__________________________________________________  Physician Signature    Date

__________________________________________________

(PRINTED) Physician Name, Address & Phone Number Physician NPI#

PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT

Eastern Shore Orthotics & Prosthetics, Inc
FAIRHOPE (251) 990-4040 * 761A Middle Street * Fax# (251) 990-0594
MOBILE (251) 471-0071 * 2504 Dauphin Street, Suite M * Fax# (251) 471-1951
STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM, THIS DOCUMENT MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT’S SYSTEMIC DIABETIC CONDITION AND THE STATEMENTS DOCUMENTED BELOW MUST BE DOCUMENTED IN THE PATIENTS MEDICAL RECORD – WHICH WE MUST ALSO RECEIVE A COPY OF TO VERIFY THE ITEMS BELOW. A SIGNED ITEMIZED DIABETIC FOOTWEAR PRESCRIPTION FORM MUST ACCOMPANY THIS FORM.

Patient’s Name: _______________________________________________ Date of Birth: ___________________

I certify that ALL of the following statements are true:

1. This patient has diabetes mellitus, ICD-9 code: _____ _____ _____ . _____ _____ (249.00 – 250.93)
2. This patient has one or more of the following conditions (check all that apply)
   a) History of partial or complete amputation of the foot
      - Amputation of toe(s) (895.0)
      - Amputation of foot (896.0)
   b) History of previous foot ulceration
      - Ulcer of heel and midfoot (707.14)
      - Ulcer other part of foot, toes (707.15)
   c) History of pre-ulcerative callus
      - History of pre-ulcerative callus (707.9)
   d) Peripheral neuropathy with evidence of callus formation
      - Polyneuropathy in diabetes (357.2) AND
   e) Foot deformity
      - Claw toe, acquired (735.5)
      - Hallux valgus, acquired (735.0)
      - Hammer toe, acquired (735.4)
      - Hallux rigidus (735.2)
      - Deformity of toe(s), acquired (735.9)
      - Deformity of ankle and foot, acquired (736.70)
      - Charcot Arthropathy (713.5)
   f) Poor Circulation
      - Atherosclerosis of extremity, unspecified (440.20)
      - Atherosclerosis of extremity with intermittent claudication (440.21)
      - Atherosclerosis of the extremity with ulceration (440.23)
      - Peripheral vascular disease, unspecified (443.9)
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (extra-depth or custom-molded shoes) and/or inserts because of his/her diabetes.
5. With diabetic footwear, the patient’s prognosis is ____________________________________________.
6. The above information is documented in the patient’s medical record, as indicated in the attached addendum to clinical notes.

CERTIFYING PHYSICIAN INFORMATION:

__________________________________________________  __________________________________________________
__________________________________________________  Physician Signature    Date
__________________________________________________  __________________________________________________

(PRINTED) Physician Name, Address & Phone Number      Physician NPI#

PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT
Eastern Shore Orthotics & Prosthetics, Inc
FAIRHOPE (251) 990-4040 * 761A Middle Street * Fax# (251) 990-0594
MOBILE (251) 471-0071 * 2504 Dauphin Street, Suite M * Fax# (251) 471-1951
ADDENDUM TO CLINICAL NOTES

Patient’s Name: _______________________________________________ Date of Birth: ___________________

Date of Last Visit: ____________________________________

This addendum is being added to the clinical notes of the above patient in order to comply with the documentation requirements of this patient’s insurance company. These findings were all observed by me while this patient has been under my care, and are hereby incorporated into my official clinical notes and I certify that a copy of this form has been placed with the patient’s chart.

1. This patient has diabetes mellitus, ICD-9 code: _____ _____ _____ . _____ (249.00 – 250.93)

2. This patient has **one or more** of the following conditions *(check all that apply)*
   - **a) History of partial or complete amputation of the foot**
     - Amputation of toe(s) (895.0)
     - Amputation of foot (896.0)
   - **b) History of previous foot ulceration**
     - Ulcer of heel and midfoot (707.14)
     - Ulcer other part of foot, toes (707.15)
   - **c) History of pre-ulcerative callus**
     - History of pre-ulcerative callus (707.9)
   - **d) Peripheral neuropathy with evidence of callus formation**
     - Polyneuropathy in diabetes (357.2) AND
   - **e) Foot deformity**
     - Claw toe, acquired (735.5)
     - Hallux valgus, acquired (735.0)
     - Hammer toe, acquired (735.4)
     - Hallux rigidus (735.2)
     - Deformity of toe(s), acquired (735.9)
     - Deformity of ankle and foot, acquired (736.70)
     - Charcot Arthropathy (713.5)
   - **f) Poor Circulation**
     - Atherosclerosis of extremity, unspecified (440.20)
     - Atherosclerosis of extremity with intermittent claudication (440.21)
     - Atherosclerosis of the extremity with ulceration (440.23)
     - Peripheral vascular disease, unspecified (443.9)

3. I am treating this patient under a comprehensive plan of care for his/her diabetes.

4. This patient needs special shoes (extra-depth or custom-molded shoes) and/or inserts because of his/her diabetes.

5. With diabetic footwear, the patient’s prognosis is __________________________.

6. I have documented this information on forms required by the patient’s insurance. I have provided these forms to a DMEPOS supplier to provide required DMEPOS.

Notes:____________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

I CERTIFY THAT A COPY OF THIS DOCUMENT HAS BEEN INSERTED INTO THE PATIENTS CHART:

__________________________________________________  __________________________________________________
Physician Name (PRINTED)     Physician Signature    Date