HOMETOWN MEDICAL

Improving Quality of Life

DIABETIC SHOE PACKET

IN ORDER TO BILL INSURANCE FOR A PAIR OF DIABETIC SHOES AND HEAT MOLDABLE INSERTS, WE NEED THE FOLLOWING PACKET COMPLETED:

1) – **STATEMENT OF CERTIFYING PHYSICIAN**- THIS FORM MUST BE FILLED OUT, SIGNED AND DATED BY THE M.D. TREATING THE PATIENT'S DIABETIC CONDITION.

2) – **PHYSICIAN'S NOTES**- THE PATIENT MUST HAVE A DIABETIC FOOT EXAM AND A COPY OF THE VISIT NOTES NEEDS TO BE SENT WITH THE ORDER.

3) – **PRESCRIPTION**- THE PERSCRIPTION FORM MUST BE FILLED OUT, SIGNED AND DATED BY THE DOCTOR. ALL APPLICABLE CONDITIONS MUST BE CHECKED.

ORDERS CAN BE FAXED TO EITHER OF OUR TWO LOCATIONS IN FLOWOOD AND VICKSBURG. A FITTER WILL THEN CONTACT YOU FOR YOUR FOOT ASSESSMENT AND FITTING.

2600 LAKELAND DR
FLOWOOD, MS 39232
(P) 601.933.4699
(F) 601.933.4988

814 BELMONT STREET
VICKSBURG, MS 39180
(P) 601.634.6363
(F) 601.634.6380

Prescription for Therapeutic Footwear

Patient Name. _____ Chart #: _____

D O.B.. _____ Today's Date: _____

Check all that apply

- ☐ Diabetes Mellitus (250.00)
- ☐ Hammertoe(s)
- ☐ Bunion(s)
- ☐ Ulcer (s)
- ☐ Callus (es)
- ☐ Amputation(s)
- ☐ Charcot Deformity
- ☐ Fasciitis
- ☐ Edema
- ☐ Neuroma
- ☐ Corn (s)
- ☐ Ankle instability
- ☐ Drop foot
- ☐ Posterior Tib. Disorder
- ☐ Peripheral Vascular Disease
- ☐ Neuropathy

The patient requires:

- o Diabetic Footwear, non custom (A5500)

With:

- o Non custom, heat moldable inserts (A5512)

Comments: _____

_____

_____

Clinician Name: _____

Signature: _____ Date: _____

Statement of Certifying Physician

Patient Name: _____ D.O.B.: _____

Chart #: _____ Medicare ID#: _____

As the physician who has the primary responsibility for treating the patient's systemic condition, I certify that all of the following statements are true:

1. I have documented in the patient's medical records that the patient has diabetes mellitus
   ICD-9 Code: _____

2. This patient has one of the following conditions:
   (check all that may apply)
   - ☐ Previous amputation of the other foot, or part of either foot, or
   - ☐ History of previous foot ulceration of either foot, or
   - ☐ History of previous pre-ulcerative callus of either foot, or
   - ☐ Peripheral neuropathy and evidence of callus formation of either foot, or
   - ☐ Foot deformity of either foot, or
   - ☐ Poor circulation (i.e. small or large vessel arterial insufficiency) in either foot

3. I am treating this patient under a comprehensive plan and care for his/her diabetes and I have primary responsibility for treating the patient's systemic condition.

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

Certifying Physician Information: (must be signed by a MD or DO)

Signature: _____ **Date:** _____

Name: _____

Address: _____

DEA#: _____ **Medicare UPIN:** _____

Enrolled in PECOS: ☐ Yes ☐ No

**It is important to note that even though you may complete and sign this 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 above are present. If required by the supplier, you must provide copies of those records.

**A new certification statement, signed and dated by the treating physician, must be provided on a yearly basis in order to obtain a new pair of shoes.