Date:

Patient Name:

MBI#:

Dear Dr. ,

Your patient, , recently received a preliminary diabetic foot evaluation which indicated that they have a significant risk of developing diabetes related foot complications and may qualify for footwear and inserts under the Medicare Therapeutic Shoe Bill.

To qualify for Medicare reimbursement, a patient's Primary Care Physician/Practitioner (MD/DO and/or NP/PA) is required to certify that the patient meets one or more of the qualifying conditions listed on the *Statement of Certifying Physician* (included).

To satisfy this requirement, we ask you to please send the patient's most recent *Diabetes Management Exam Notes* (**1**) and complete and return the attached forms (**2 and 3**):

1. Diabetes Management Exam Note

- Within last 6 months
- Signed and dated by **MD/DO and/or NP/PA**
    - If authored and signed by NP/PA, the supervising MD/DO will also need to sign

2. Statement of Certifying Physician/Practitioner

- Complete, Sign, and Date by **MD/DO and/or NP/PA**
    - If signed by NP/PA, the supervising MD/DO will also need to sign

3. Diabetic Foot Exam

- Includes prescription
- Indicate agreement, Sign, and Date

Please fax the completed forms back to us at and place a copy of this information in the patient's chart.
Your cooperation is very much appreciated. If you have any questions or need additional information, please contact us at –
.

Sincerely,

PLEASE FAX TO:

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES AND INSERTS

Patient Name:		**MBI#:**		**DOB:**	

Please complete this Statement of Certifying Physician for the patient listed above so that we may provide them with therapeutic shoes and inserts.

To qualify for Medicare reimbursement, it is required that the Primary Care Physician/Nurse Practitioner certify that the patient meets one or more of the conditions listed below.

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
   - ☐ Type I ICD-10 Code(s): _____
   - ☐ Type II ICD-10 Code(s): _____
2. This patient has one or more of the following conditions (indicate all that apply):
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ Poor circulation

   Please make certain these condition(s) are consistent with and supported by clinical findings noted in the patient's Diabetes Management Exam Notes
3. I am treating this patient under a comprehensive plan of care for diabetes.
4. This patient needs special shoes to help prevent complications resulting from diabetes.

Primary Care Signature: (NP/PA and/or MD/DO)		**Date:**	
Primary Care Name: (Printed)		**NPI:**	
Primary Care Address:			

This form **may only be completed and signed by a NP/PA and/or MD/DO. If completed and signed by NP/PA, the supervising MD/DO will also need to sign in acknowledgement. No stamped signatures permitted.*

Please fax back the completed form along with the exam note from the patient's chart supporting what's noted above. The original should be saved in the patient's chart.

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