DIABETIC FOOTWEAR PRESCRIPTION FORM

Patient:______________________________ DOB: ______________

Date of Order: _________________________ HICN: ______________

Quantity: (please check)	HCPCS Code:	Description:
☐ 1 Pair	A5500	Diabetic Depth Shoes, pair
☐ 3 Pair	A5512 OR	Prefabricated inserts pairs-multiple density, direct formed, molded to foot with external heat source (i.e. heat gun). Medicare allows three pairs of inserts per year.
☐ 3 Pair	A5513	Custom-molded inserts – multiple, density, molded to model of the patient's foot. Medicare allows up to three pairs of inserts per year.

☐ 1 Left Partial Foot Filler (L5000)

☐ 1 Right Partial Foot Filler (L5000)

☐ 3 Right Custom Inserts

☐ 3 Left Custom Inserts

Primary ICD-10 Diagnosis Code: ________ . _____

(According to "Physician Notes on Qualifying Condition(s)")

Please confirm that the entered Diagnosis Code matches your charting documentation.

Duration of usage: 12 Months

Prescriber Signature: X______________________ Date:______________

(Stamped signature not allowable)

Prescriber Name: (printed) ______________________ NPI________________

Must be the MD, DO or other eligible prescriber who is actively treating patient's diabetes. Can be PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)

STATEMENT OF CERTIFYING PHYSICIAN
for Therapeutic Shoes

Documentation must be in your records to indicate that **you are managing the patient's diabetes** and that **one of the conditions listed below is present.** If requested by the supplier, you must provide copies of those records.

Patient: ____ DOB: ____________________

1 This patient has diabetes mellitus: ☐ Type II ☐ Type I

(Diabetes ICD-10 Codes: E08.00 - E13.9)

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
- ☐ b. History of previous foot ulceration
- ☐ c. History of pre-ulcerative callus
- ☐ d. Peripheral neuropathy with evidence of callus formation
- ☐ e. Foot deformity (can include: thickened and hard to trim toenails, ingrown toenails, corns, calluses, bunions, deformed or hammered toes)
- ☐ f. Poor circulation

3 Not only am I treating this patient under a comprehensive plan of care for Diabetes, but I also recently saw this patient in-person on ____ / ____ /_____. Their staged diagnosis has been personally documented by me in their file.

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

5 The above information is documented in the patient's medical record, **as indicated in the attached clinical notes**.

Physician Signature (MD or DO): **X**________________________________ Date: ________________

*** PA-C's or ARNP's are not eligible to sign this form per Medicare guidelines for Therapeutic Shoes ***

Physician Name: ___________________________________ NPI #: ____________________

Physician Address: _________________________________

____

PHYSICIAN NOTES ON QUALIFYING CONDITION(S) FOR THERAPEUTIC SHOES

Patient Name: ______________________________________ HICN: _____________________

Date of Exam: _____________________

1 Diabetes Type:

☐ Type I, Controlled **(1)** ☐ Type II, Controlled **(0)** ☐ Type I, Uncontrolled **(3)** ☐ Type II, Uncontrolled **(2)**

2 Diabetes Management (Required supporting discussion of diabetes management)

Plan of Care: ☐ Diet ☐ Oral Meds ☐ Injection ☐ Pump

Treatment Plan:

Start Date: _______________ Duration of DM: ____________ Date of Last FBS: _______________

3 Physical Exam:

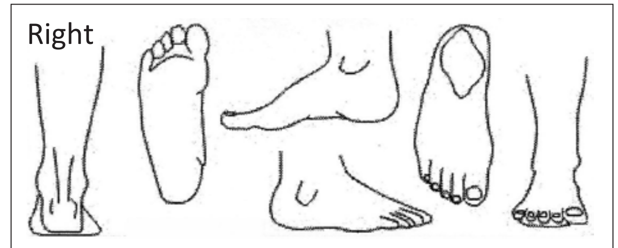
Neurological (use Y / N)	**Right**	**Left**
Loss of Vibration Perception		
Loss of Protective Sensation		

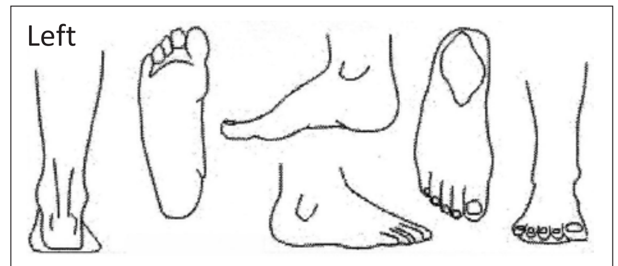
Vascular (circle appropriate level)	**Right**	**Left**
Dorsalis Pedis (3 = normal)	0 1 2 3 4	0 1 2 3 4
Posterior Tibial (3 = normal)	0 1 2 3 4	0 1 2 3 4

4 Physical Exam Part 2: Please refer to the findings when noting secondary risk factor(s) on "Statement of Certifying Physician"

Please Indicate any calluses, bunions, swelling, redness, deformities, amputation or wounds using the symbol key below:

Callus **C** Bunion **B** Swelling **S** Redness **R**
Deformity **D** Hammer/Claw Toe **HC**
Amputation **A** History of Pre-Ulcer Callus **HPC**
Wound **W** History of Previous Ulceration **HU**





5 Diagnosis Code: ___________ . ___________

6 Certifying Physician Acknowledgment*

I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I have personally conducted this foot examination **or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings**. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and inserts.

Physician Signature: **X** ________________________________ Date: ____________________

(Stamped signature not allowable)

Physician Name (Printed): ________________________________ Physician NPI #: ______________

FOR MD/DO USE FOR FOOT EXAM <u>IF NEEDED</u>