STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR
(Therapeutic Shoe Bill)

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM
FORM MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION.

PATIENT NAME: _____ Date of Birth: _____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus ICD-9 Code: **2**_____ _____. ____ ____ (**Five digit ICD-9 Diagnosis Code Required 249.00-250.93**)
2) This patient has **one or more** of the following conditions (**check all that apply**):

HISTORY OF PARTIAL *OR* COMPLETE AMPUTATION OF THE FOOT
- ☐ Lower limb amputation, foot (V49.73 & 755.38)
- ☐ Lower limb amputation, great toe (V49.71 & 755.39)
- ☐ Lower limb amputation, lesser toe(s) (V49.72 & 755.39)

HISTORY OF PREVIOUS FOOT ULCERATION
- ☐ Ulcer of heel and midfoot (707.14)
- ☐ Ulcer other part of foot (707.15)

HISTORY OF PRE-ULCERATIVE FOOT CALLUS
- ☐ History of pre-ulcerative callus (707.9)

PERIPHERAL NEUROPATHY *AND* EVIDENCE OF CALLUS FORMATION
- ☐ Polyneuropathy in diabetes (357.2) WITH Callus formation (700)

FOOT DEFORMITY
- ☐ Claw toe (735.5)
- ☐ Hammer toe (735.4)
- ☐ Hallux valgus (735.0)
- ☐ Hallux rigidus (735.2)
- ☐ Charcot Arthropathy (713.5)
- ☐ *Other ICD-9 Code*:_____

POOR CIRCULATION IN EITHER FOOT *(MUST INDICATE WHICH FOOT)*
- ☐ Atherosclerosis of the extremities, unspecified (440.20)
- ☐ Atherosclerosis of the extremities with intermittent claudication (440.21)
- ☐ Atherosclerosis of the extremities with ulceration (440.23)
- ☐ Peripheral vascular disease, unspecified (443.9)
- ☐ *Other ICD-9 Code*:_____

COVERED PROCEDURES:

CIRCLE THE # OF PAIRS

- ❑ **Diabetic Extra Depth Shoes (A5500)**
- ❑ **Custom Inserts (A5513)** (avg. life is 4 months each pair*) **# of pair**: 3 2 1 (Medicare allows up to 3 pair*)
- ❑ **Prefab Inserts** (heat molded prefab-avg. life is 4 months each pair*) (**A5512)** Will not work for all foot types. **# of pair**: 3 2 1 (Medicare allows up to 3 pair*)
- ❑ **Custom Toe Filler** (L5000) (Left Right) **# of units per foot**: 2 1 (Medicare allows up to 2 units*)
- ❑ **Custom Molded Shoes (A5501)** Must have severe deformity **and total of 2 pairs of custom inserts (A5513)**

***Modifications MUST be caused from diabetes to be covered**

- ❑ **Rigid Rocker Bottom Sole or Bar** (**A5503)**
- ❑ **Sole/Heel Wedge** (please circle one) (**A5504)**
- ❑ **Metatarsal Bar** (**A5505)**
- ❑ **Other Modifications** (Medial Stabilizers, Lateral Stabilizers, etc.) (**A5507)**

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.
4) This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.
5) **By signing below I certify the above information is documented in the patient's medical record.**

CERTIFYING PHYSICIAN INFORMATION:
(***MEDICARE REQUIRES SIGNATURES TO BE LEGIBLE***)

_____ **MD** or **DO**
Physician Name (printed) (must be legible) (circle one)

_____
Physician Signature (must be legible) Date

_____
Physician Address

_____
Physician NPI #

_____
Physician Phone #

PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT

FRED TOENGES SHOES & PEDORTHICS
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