ADVANCED
PROSTHETICS AND ORTHOTICS
"The Patient Care Specialists"

Requirements for Diabetic Shoes

- Diabetic Verification Form must be completed by the medical doctor treating the patient for diabetes.
- Foot Evaluation Form must be signed by the medical doctor treating you for diabetes (even if the podiatrist already signed it)
- Signed Medical forms are only valid for 90 days from signature date. Any device must be delivered in that time frame or new paperwork will be required.

- ***Medical records must accompany the Diabetic Shoe paperwork indicating where the patient was seen by a clinician on the same date as the diabetic forms were signed.***

For Prescribing Physicians:

- On the foot evaluation form please make sure you have noted any clinical concerns (callus, amputation, wounds, etc.)
- Foot Evaluation may be completed and/or signed by clinician performing evaluation (NP, PA, Podiatrist or Etc) but MUST also be signed by the medical doctor that is treating the patient for diabetes.

- The Diabetic Verification form must be filled out completely and at least one selection made on all parts.

- A dated entry must be made in the patient records to indicate the signing of any forms related to diabetic shoes and inserts on the date the forms were signed in order for the documents to meet Medicare's requirements for diabetic shoes and inserts. ***Please send patient with the last six months of medical records.***

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Prosthetics and Orthotics

Fax: 912-226-7644

Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

Patient Phone #: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (circle 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
   f) Poor circulation

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) because of his/her diabetes.

Physician signature: X _____

Date Signed: _____

Physician name (Printed-**MUST BE AN M.D. OR D.O.**)

_____

Physician address:

_____

_____

_____

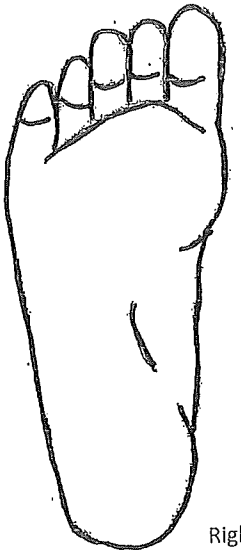
Physician NPI: _____

Evaluation Form

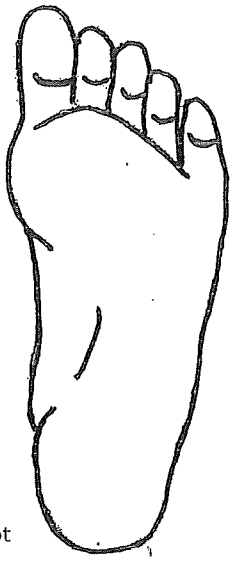
Therapeutic Shoes and Inserts

Patient Name: _____ **Evaluation Date:** _____

Indicate clinical concerns on diagram below:
Ulceration, callus formation, edema, sensation, infection, discoloration, amputation, etc.



Right Foot



Left Foot

Additional deformity details (if needed)

_____

_____

_____

Performed by _____
(Print Name)

Signature _____ MD/DO/DPM/PA/NP/CNS

Signature X _____ M.D/DO. Date: _____

(Required signature of diabetes treating MD/DO if exam performed by other clinician)