90 Springview Lane

Summerville, SC 29485

843-439-5311

843-948-6212 (Fax Number)

Thank you for choosing Palmetto Orthotics and Prosthetics!

We look forward to caring for you. Your insurance provider requires that we collect specific documentation from you and your doctor to support medical necessity for therapeutic shoes and inserts.

Prior to scheduling your appointment, please obtain these three supporting documents:

• A Statement of Certifying Physician for Therapeutic Shoes (Page 2)

◦ This document certifies your need for therapeutic shoes. ◦ This must be completed and signed by the physician who is treating your diabetes.

This physician must be an MD or DO.

• A Standard Written Order (Page 3)

◦ This document specifies the item(s) that the ordering provider is requesting be provided to you. ◦ The ordering provider can be your doctor, podiatrist, nurse practitioner, physician assistant or clinical nurse specialist.

• Clinical Evaluation/Notes (Acquire directly from your doctor)

◦ Your doctor can print and provide to you or fax to our office. ◦ Notes must document that the physician is treating your diabetes and must be from the same physician that completes the Statement of Certifying Physician noted above. ◦ Notes must indicate medical necessity for therapeutic shoes in the treatment of your diabetes. ◦ The evaluation must be within 6 months prior to receiving your shoes and/or inserts.

If you have not seen your diabetic physician within the last 6 months, you will be required to schedule an appointment to have the examination completed. Your doctor may fax the required documentation directly to Palmetto Orthotic and Prosthetic Center or you may bring it in. Once we receive these documents, we will review them and call you to schedule your evaluation/fitting appointment.

Please note, the requested information is a requirement of your insurance provider. If you have any questions, please contact us with any questions.

Therapeutic Shoes for Persons with Diabetes Statement of Certifying Physician All fields are required by payer to be completed by the certifying physician

Last name: _____ **First name**: _____ MI: ____

DOB: _____

Medicare/Ins ID: _____ **Date of Last Diabetic Exam**: _____

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 (check 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

3. I am treating this patient under a comprehensive plan for his/her diabetes.

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

_____

Signature, name, date, and NPI (must be an M.D. or D.O.)

Name (Printed): _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____

Signature: _____ Date: _____

Standard Written Order for Therapeutic Shoes for Diabetes All fields are required by payer to be completed by the certifying physician

Patient name: _____ **DOB**: _____

Date of Order: _____

Diagnosis: _____

Shoes (please circle)

◦ Extra Depth (left) (right) or Custom made and molded (left) (right)

Inserts (please circle)

Pairs 1 2 3

◦ Custom Molded Inserts Pairs

◦ Toe Filler (Left) (Right)

◦ Prefabricated (Left) (Right)

◦ Custom Fabricated (Left) (Right)

◦ Other: _____

Additional Instructions: _____

_____

Ordering Physician Information Name (Printed):

_____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____

Signature: _____ Date: _____