

STATEMENT OF CERTIFYING PHYSICIAN FORM + DETAILED WRITTEN

Patient Name: _____

DOB: _____

STATEMENT OF CERTIFYING PHYSICIAN (SOC)

1. The patient has **DIABETES MELLITUS** (ICD-10) diagnosis codes E.9--E10.65); and

2. The patient has one or more of the following conditions:

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | a) History of partial or complete amputation of the foot. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | b) History of previous foot ulceration. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | c) History of pre-ulcerative callus. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | d) Peripheral neuropathy with evidence of callus formation. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | e) Foot deformity. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | f) Poor circulation. |

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

4. This patient needs diabetic shoes.

Medical Necessity Certification (required)

Therapeutic shoes and inserts are medically necessary to protect the feet, reduce risk of ulceration and skin breakdown, and accommodate deformity and/or neuropathy-related pressure points due to diabetes-related foot changes. I certify that all of the preceding statements are true.

Certifying Practitioner Printed Name: _____

NPI: _____

Date: _____

.....
Signature (Must be an MD or DO / No stamp signature / no stamp date)

DETAILED WRITTEN ORDER (DWO)

Instructions: Please make any necessary changes to reflect the patient's status, initial any changes and sign below to confirm the patient's need for therapeutic shoes.

Item(s) Ordered:

1. A5500 Therapeutic depth shoes --- 1 pair
2. A5512 Prefabricated inserts --- 3 pairs / 6 units

Diagnosis/Indication: Diabetes Mellitus with qualifying condition(s) checked above.

Detailed Description / Medical Need (required):

Therapeutic footwear and inserts required for pressure redistribution, accommodation of deformity and/or neuropathic pressure points, and prevention of ulceration and skin breakdown.

Ordering/Certifying Practitioner Printed Name: _____

NPI: _____

Date: _____

.....
Signature

Paul Shoes / FAX: (323) 389-0999 / Milano Shoes

If additional form needed, go to www.paulshoesform.com

MEDICARE PROGRESS NOTE FOR DIABETIC SHOES CERTIFYING VISIT

(Therapeutic Shoes for Persons with Diabetes -- Certifying Physician Visit Note)

Date of Visit: _____ DOB: _____

Patient Name: _____

CHIEF COMPLAINT / REASON FOR VISIT

Patient here today for diabetes management follow-up and diabetic foot exam for certification of medical necessity for therapeutic diabetic shoes and inserts.

VITALS: BP: _____ HR: _____ Temp: _____

DIAGNOSIS

Diabetes Mellitus: Type 1 Type 2 ICD-10: _____

CURRENT DIABETES PLAN OF CARE

I am treating this patient under a comprehensive plan of care for diabetes.

Diabetes Medications: _____

None

Plan includes (check): Diet Exercise Monitoring Medication mgmt Other: _____

DIABETIC FOOT EXAM / QUALIFYING CONDITIONS (check all that apply)

Hx partial/complete foot amputation: _____

Hx previous foot ulceration: _____

Hx pre-ulcerative callus: _____

Peripheral neuropathy with evidence of callus formation

Callus present: L R Location: _____

Foot deformity (bunion/hammertoe/claw toe/Charcot/pes planus/cavus/other): _____

Poor circulation (PVD/PAD) with findings: dec pulses skin thin/shiny temp ↓ color change edema

venous stasis

ASSESSMENT & PLAN

The patient has diabetes mellitus and qualifying foot condition(s) above, placing the patient at increased risk for skin breakdown and ulceration.

1. Continue diabetes plan of care and follow-up.
2. Foot care counseling given (daily checks, hygiene, report wounds).
3. Therapeutic shoes and inserts medically necessary for pressure redistribution, protection, and prevention of ulceration/skin breakdown.
4. Proceed with diabetic shoes/inserts per signed DWO.

This was an in-person visit. Findings support medical necessity for Medicare-covered therapeutic shoes/inserts.

Certifying MD/DO Printed Name: _____ NPI: _____

Date: _____

.....
Signature (Must be MD or DO / No stamp signature / no stamp date)

FAX: (323) 389-0999

Please be advised that all visits are by appointment only.

Contact us at **(818) 507-0314** to arrange your appointment prior to your visit.

Մենք ընդունում ենք միայն նախապես նշանակված ժամադրությամբ:

Խնդրում ենք նախապես զանգահարել **818-507-0314** հեռախոսահամարով՝ ձեր ժամադրությունը ամրագրելու համար:

PAUL'S SHOES

1102 S. GLENDALE AVE.
GLENDALE, CA. 91205
TEL: (818)507-0314

MILANO SHOES

5207 W. SUNSET BLVD.
LOS ANGELES, CA. 90027
TEL: (323)661-8004

FAX:(323)389-0999