SEWALL'S POINT PHARMACY
Compounding & Wellness Specialists

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Stuart, FL 34996
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Diabetic Therapeutic Footwear and Inserts

Required Documentation

We are accredited to bill Medicare for fitting and dispensing therapeutic diabetic footwear and inserts for qualified patients. In-order for a patient to qualify for Medicare reimbursement, a patient's Physician (MD/DO) is required to provide documentation to certify that the patient meets one or more of the qualifying conditions listed on the Statement of Certifying Physician (included). To satisfy this requirement, we ask you to please send the following documentation to us:

1. **Diabetes Management Exam Note**
   - Within last 6 months
   - Signed and dated by MD/DO
2. **Statement of Certifying Physician/Practitioner (enclosed)**
   - Complete, Sign, and Date by MD/DO
3. **Diabetic Foot Exam Documentation (or use enclosed)**
   - Indicate agreement, Sign, and Date
   - Within last 6 months
4. **Prescription for Therapeutic Shoes and Inserts (enclosed)**
   - Includes prescription
   - Indicate agreement, Sign, and Date

Please fax the requested items (1-4) to us at **(772) 600-5576** and place a copy of this information in the patient's chart.

Your cooperation is very much appreciated. If you have any questions or need additional information, please do not hesitate to contact us.

Regards,

Cristal Totterman, PharmD.

PLEASE FAX TO:

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES AND INSERTS

Patient Name:		MBI#:		DOB:	

Please complete this Statement of Certifying Physician for the patient listed above so that we may provide them with therapeutic shoes and inserts.

To qualify for Medicare reimbursement, it is required that the Primary Care Physician/Nurse Practitioner certify that the patient meets one or more of the conditions listed below.

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
   - ☐ Type I ICD-10 Code(s): _____
   - ☐ Type II ICD-10 Code(s): _____
2. This patient has one or more of the following conditions (indicate 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

   Please make certain these condition(s) are consistent with and supported by clinical findings noted in the patient's Diabetes Management Exam Notes
3. I am treating this patient under a comprehensive plan of care for diabetes.
4. This patient needs special shoes to help prevent complications resulting from diabetes.

Primary Care Signature: (NP/PA and/or MD/DO)		Date:	
Primary Care Name: (Printed)		NPI:	
Primary Care Address:			

This form **may only be completed and signed by a NP/PA and/or MD/DO. If completed and signed by NP/PA, the supervising MD/DO will also need to sign in acknowledgement. No stamped signatures permitted.*

Please fax back the completed form along with the exam note from the patient's chart supporting what's noted above. The original should be saved in the patient's chart.

PLEASE FAX TO:

DIABETIC FOOT EXAM

Patient Name:		MBI#:		DOB:	

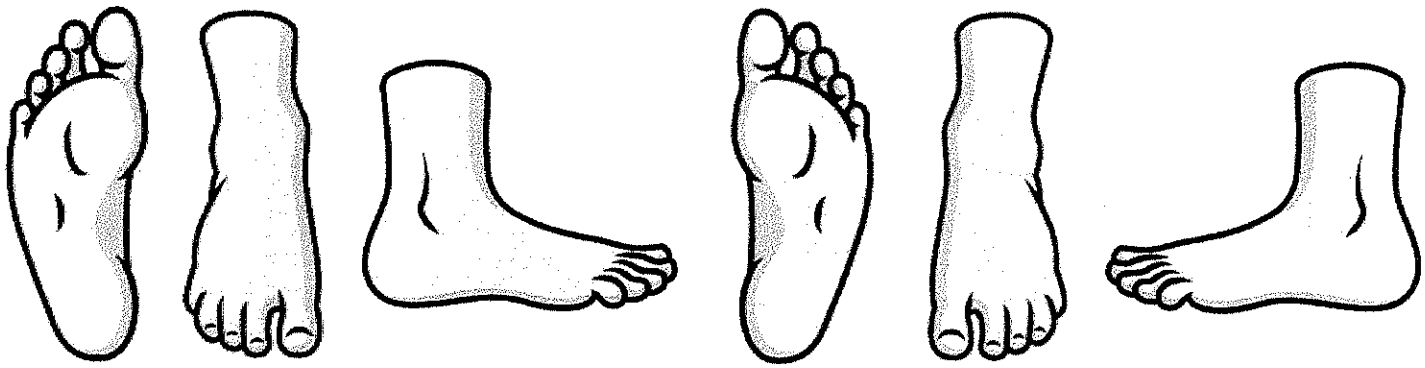
Patient concerns and history:

_____

_____

Diabetic foot exam performed today to identify risk and need for therapeutic shoes and inserts:

RIGHT FOOT **LEFT FOOT**



Note deformities on the images above using the symbol key below:

A: Amputation **B**: Bunions **C**: Callus **H**: Hammer Toes **R**: Redness **S**: Swelling **W**: Wound/Ulcer

Amputation: ☐ Left ☐ Right
Bunions: ☐ Left ☐ Right
Callus: ☐ Left ☐ Right
Hammer Toes: ☐ Left ☐ Right
Redness: ☐ Left ☐ Right
Swelling: ☐ Left ☐ Right
Wound/Ulcer: ☐ Left ☐ Right

Cognitive Awareness: ☐ Normal ☐ Abnormal
Fat Pads: ☐ Normal ☐ Abnormal
Foot Color: ☐ Normal ☐ Abnormal
Range of Motion: ☐ Normal ☐ Abnormal
Skin Temperature: ☐ Normal ☐ Abnormal
Skin Integrity: ☐ Normal ☐ Abnormal

DPM Signature:		DPM Name: (Printed)		Date:	

***Certifying Physician/Practitioner Acknowledgement:** I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I agree with the above foot examination conducted by this patient's podiatrist, or eligible prescriber, and agree with the findings and the need for the products listed. 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.

Primary Care Signature: (MD or DO)		Date:	
Primary Care Name: (Printed)		NPI:	
Primary Care Address:			

PLEASE FAX TO:

PRESCRIPTION FOR THERAPEUTIC SHOES AND INSERTS

Patient Name:		MBI#:		DOB:	

Quantity	HCPCS Code	Description
1	A5500	Anodyne Diabetic Extra-Depth Shoes, pair
3	A5514	Anodyne Custom Fabricated Inserts, pair

Other: _____

_____

Therapeutic Objectives:

☐ Prevent Ulceration and other pedal complications

☐ Distribute weight, balance, and plantar pressure

Duration of Usage: 12 Months

DPM Signature:		Date:	
DPM Name: (Printed)		NPI:	
DPM Address:			

**Please ensure this form is completed only by the DPM. No stamped signatures permitted.*

Size based on foot measuring device and fitting inventory:

Shoe Order Information	
Style No:	
Color:	
Size:	
Width:	

Foot Measurements		
	Left	Right
Heel to Toe:		
Heel to Ball:		
Width:		

Foot Model Type
☐ 3D Scan
☐ Foam Impression
☐ Slipper Cast