OrthoCare
ORTHOTICS & PROSTHETICS, INC.

1501 N. Hwy 441 building 1100 suite 1108 The Villages, Fl. 32159 (352)751-7265:
Fax(352)751-4447

Insurance Required Documentation for diab shoes.

Step 1. Pick-up diabetic shoe packet from OrthoCare.

Step 2. Schedule an appointment with your Dr who treats your diabetes. Must be an MD or DO. This can not be your podiatrist or an ARNP.

Step 3. Take this packet of paperwork with you to your appointment, it must be completed at a face to face office visit.

Step 4. Have your Dr fax all of the completed forms to OrthoCare. (signed RX, diab cert, and office notes that include a foot exam)

Step 5. Once we receive the completed packet, It will be sent to Medicare for them to review. This take aprox 3 weeks. If prior authorization is needed we will submit one.

When the documentation is approved, we will call you to schedule an appointment.

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Patient_____ DOB_____

Dear DR_____

Your patient contacted our office and would like to benefit from diabetic shoes and inserts and have them covered by their Insurance. There must be detailed documentation in the office notes to qualify them

MEDICARE REQUIRED GUIDELINES COMPLETED IN THIS ORDER

Only an MD can certify for diabetic shoes

1. A foot exam must be done and documented. If the MD doesn't want to complete the foot exam he can use a foot exam from the NP or DPM. (Exam done in last 3 months) The certifying MD must sign and date the foot exam notes stating he agrees with the foot exam findings.

2. Have an office visit with the certifying MD and Document in those notes the treatment of diabetes and patient needs diabetic shoes as part of the treatment plan. Include meds taken and labs completed.

   THIS MUST BE DONE AND DATED THE SAME DAY OR BEFORE SIGNING THE DIAB CERT AND SCRIPT.

3. Once all the documentation is completed Then the MD can sign the certification form and circle the condition that qualifys the patient in the documentation. And then he can sign the script.
4. Please fax to our office the completed signed notes, the diabetic cert and the prescription to our office. 352 751-4447 We then send them to medicare for approval.

Thank you for understanding Insurance guidelines. Per Medicare these forms will only be good for 3 months.

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www.orthocarecfl.com

RX/Certificate of Medical Necessity

Patient_____ Initial/Date_____

Diagnosis_____ DX Code _____

☐ Left ☐ Right ☒ Bilateral

UPPER EXTREMITY:

- ☐ Wrist Immobilizer
- ☐ Thumb Spica
- ☐ Sling & Swathe
- ☐ Elbow IROM brace set @ _____

SPINAL:

- ☐ TLSO
- ☐ LSO
- ☐ TL Corset
- ☐ LS Corset

LOWER EXTREMITY:

- ☐ Pneumatic Walking Boot ☐ Tall ☐ Short
- ☐ Achilles Boot c_____° PF
- ☐ Lace-up Ankle Brace
- ☐ Airstirrup
- ☐ Custom AFO
- ☐ Custom Articulating AFO
- ☐ Baldwin Boot
- ☐ Carbon Fiber AFO
- ☐ Knee Immobilizer
- ☐ IROM Knee Brace Set @ _____
- ☐ OA Knee Brace Unload med/lat
- ☐ ACL Brace
- ☐ Hinged Knee Brace

- ☐ Custom Foot Orthoics
- ☒ 1 pr. Diabetic Shoes
- ☒ 3 pr. Custom Diabetic Inserts

PROSTHETICS:

- ☐ AK Prosthesis
- ☐ BK Prosthesis
- ☐ Stump Shrinker
- ☐ Stump Socks

OTHER

_____

_____

I, the undersigned, have reviewed the above information and certify that the above prescribed device is reasonable and necessary according to accepted standards in the treatment of this condition and is not prescribed as a convenience device.

_____ MD/DO Date _____

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

HIC #: _____

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

*Please circle all that apply in section #2.

*Sentences #3 and #4 must be physically written the the office notes.

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: _____

Date Signed:_____

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

_____

Physician address:

_____

_____

_____

Physician NPI _____

Please complete and return to:

OrthoCare
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Phone: 352-751-7265 Fax: 352-751-4447

This form, a signed Rx, and the office notes must all be completed and signed with the same date of service. These forms are only good for 3 months.