Dear Doctor,

I recently received a preliminary diabetic foot evaluation which indicated that I have a significant risk of developing diabetes related foot complications and may qualify for footwear and inserts under the Medicare Therapeutic Shoe Bill.

To qualify for Medicare reimbursement, the physician that treats & handles my diabetes (MD, DO or NP*) is required to certify that the patient meets one of the qualifying conditions listed on the Statement of Certifying Physician (included).

To satisfy this requirement, I ask that you please provide my most recent Diabetes Management Exam Notes **(1)** and complete the attached forms **(2 and 3):**

1 Diabetes Management Exam Note

- Signed and dated by **MD, DO or NP* only.**
- Within last 6 months : Signed and Dated.

Foot findings must support items checked on the Statement of Certifying Physician.

- Foot finding notes can come from NP* or DPM with a signature from the treating MD or DO.

2 Statements of Certifying Physician

- Complete, Sign, and Date by **MD, DO or NP * only.**

3 Prescription for Diabetic Shoes and Inserts

- Complete, Sign, and Date by ***DPM*, MD, DO, PA, NP or CNS** who performed the CMS or CGS Foot Exam.

**** NP - See article Therapeutic Shoes for Persons with Diabetes Policy Article A52501.***

If you cannot immediately provide these documents please fax them to:

Wright & Filippis

248-493-6056

Supplier Contact Info

WRIGHT&FILIPPIS®

Statement of Certifying Physician

Patient:_____

Patient D.O.B.:_____

Date of last visit:_____

Medicare MBI #:_____

1. This patient has diabetes mellitus:
   - ☐ *Type 1* ☐ *Type 2*
2. QUALIFYING CONDITIONS: I have diagnosed and am including my notes showing that this patient has one or more of the following:
   - ☐ 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 (i.e., small or large vessel arterial insufficiency) in either foot.*
3. I am treating this patient under a comprehensive plan for care of his/her diabetes
   - Must have In-person visit within 6 months prior to delivery of shoes/ inserts
4. This patient needs special shoes (extra depth or custom molded) because of his/her diabetes
5. This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes

Must be signed on or after date of in-person visit and within 3 months prior to delivery of shoes.

Physician Signature:_____

Must be an M.D., D.O. or N.P.*

Physician Name:_____

NPI #:_____ Date:_____

Physician Phone:_____

Physician Address:_____

PLEASE FAX TO: 248-493-6056

Prescription for Diabetic Shoes and Inserts

Patient:_____

Patient D.O.B.:_____

Date of last visit:_____

Diagnosis Code: _____

Medicaid ID #: _____

1. Type of **shoes** prescribed (**Must select an option**):
   - ☐ *Off the shelf shoes* ☐ *1 pair*
   - ☐ *Custom fabricated shoes* ☐ *1 pair*
2. Types of **inserts** prescribed (**check one**):
   - ☐ *Off the shelf inserts* ☐ *3 pair*
   - ☐ *Custom fabricated inserts* ☐ *3 pair*
3. Types of other accommodations (if applicable):

R	L	
☐	☐	*Rocker Bottom - per shoe*
☐	☐	*Wedge - per shoe*
☐	☐	*Metatarsa - per shoe*
☐	☐	*Off Set Heel - per shoe*
☐	☐	*Toe Filler - per shoe (must have amputation diagnosis)*

Diagnosis: _____

Physician Signature:_____

Must be an M.D. or D.O., D.P.M., P.A., N.P., or Clinical Nurse Specialist

Physician Name:_____

NPI #:_____ Date:_____

Physician Phone:_____

Physician Address:_____

PLEASE FAX TO: 248-493-6056