CHECK 7

REQUEST FOR DOCUMENTATION FROM CERTIFYING PHYSICIAN

GENUINE Dr.Comfort EST. USA

Patient Info

PATIENT NAME	RECORD ID
MBI	DATE OF BIRTH
TODAYS DATE	

Re: Diabetic Footwear Documentation Request

Dear Dr. _____

I am writing to request your assistance in providing the above patient with diabetic footwear, as provided under the Therapeutic Shoes for Persons with Diabetes Act (TSPD) SSA 1861 (s)2. In order to qualify for Medicare reimbursement, your certification that they meet certain conditions is required, as well as a prescription for diabetic shoes and inserts.

May I ask you to please review and complete the attached forms as follows:

☑ Statement of Certifying Physician - complete, sign and date

☑ Copy of your patient notes indicating:

a. Management of the Diabetes and last visit

Copy of your notes:

☑ Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement;

- or -

☑ Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

Fax or email these back to us at: 651-735-0011

Please do not hesitate to call me at 651-735-9192 if you have any questions. I greatly appreciate your assistance in serving the needs of this patient.

Sincerely,

Carrie Weihrauch

Superior Medical Services
7582 Currell Blvd. #110
Woodbury, MN 55125
P: 651-735-9192
F: 651-735-0011

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T 800.556.5572
10300 North Enterprise Drive | Mequon, WI 53092 | U.S.A.
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STATEMENT OF CERTIFYING PHYSICIAN

GENUINE Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

I hereby certify that the patient mentioned above:

1. Has Diabetes
   - ☐ Type I (ICD-10 Code(s): _____)
   - ☐ Type II (ICD-10 Code(s): _____)
2. This patient has the following conditions (check 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
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
PHYSICIAN NAME	NPI#

PHYSICIAN ADDRESS

CITY	STATE	ZIP CODE

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CERTIFYING PHYSICIAN ATTESTATION PRESCRIBING PHYSICIAN'S NOTES

GENUINE® Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

Patient Notes Including Diagnosis of Qualifying Condition

Examining Physician Signature:

SIGNATURE	
PRINT NAME	DATE

Attesting Physician Signature: I have reviewed the above diagnosis and agree with the findings. I am including a copy of this diagnosis in the patient's file.

SIGNATURE	
PRINT NAME	DATE

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STANDARD WRITTEN ORDER

GENUINE Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

TODAY'S DATE

Check all that apply

- ☐ DIABETES MELLITUS
- ☐ CALLUS(ES)
- ☐ CORN(S)
- ☐ ULCER(S)
- ☐ HAMMERTOE(S)
- ☐ AMPUTATION(S)
- ☐ POOR CIRCULATION
- ☐ OTHER:
- ☐ BUNION(S)
- ☐ CHARCOT DEFORMITY
- ☐ NEUROPATHY WITH EVIDENCE OF CALLUS FORMATION

Others

THE PATIENT REQUIRES

☐ THERAPEUTIC FOOTWEAR, NON-CUSTOM (A5500) - 1 PAIR (UNLESS OTHERWISE INDICATED)
WITH (SELECT ONE OPTION FROM BELOW)

☐ NON-CUSTOM, HEAT MOLDABLE (A5512) – 3 PAIRS (UNLESS OTHERWISE INDICATED)

☐ CUSTOM MOLDED INSERTS (A5513/A5514) – 3 PAIRS (UNLESS OTHERWISE INDICATED)

☐ LESIONS REQUIRING OFFLOADING (IF NECESSARY) L ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
R ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

☐ TOE FILLER (L5000)

☐ INDICATE MISSING DIGITS L ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
R ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

COMMENTS

Prescriber's Name

PRESCRIBING PHYSICIANS NAME

SIGNATURE	DATE

NPI# OF ORDERING ENTITY (M.D./D.O./DPM/PA/CNS/NP)

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