Allegheny

ORTHOTICS & PROSTHETICS

PROCESS FOR OBTAINING DIABETIC SHOES AND INSERTS

Instructions for Patient

In order for us to bill your insurance we must have **ALL** of the following documentation from your physician **BEFORE** we can see you to order shoes and inserts.

1. Make an appointment with the doctor who treats you for your diabetes to have a foot exam performed.
2. Take this packet with you to your appointment & give it to the doctor to complete.
3. Once all forms are completed, call to make your appointment with our facility.
4. Bring the completed forms, your insurance card(s) & a photo ID to your appointment to be evaluated and to select shoes.

Once our billing office is able to verify that we have obtained all of the required documentation, your items will be ordered. You will then be contacted for fitting and delivery as soon as they are available.

Thank you for your cooperation!

DOCUMENTATION REQUIREMENTS FOR THE PRESCRIBING PHYSICIAN

1. Please include in your office notes what you prescribed for your patient and why you prescribed it for him/her. For instance, I gave Jane Smith a prescription for Diabetic Shoes and Inserts. She has peripheral neuropathy, callus formations, and bunions.
2. There also need to be details of the foot exam that you performed on your patient if you are prescribing diabetic shoes and inserts. There needs to be specific details of one of the qualifying conditions. It must describe:
    a. The specific foot deformity (e.g., bunion, hammer toe, etc); or
    b. The location of a foot ulcer or callus or a history of one of these conditions; or
    c. The type of foot amputation; or
    d. Symptoms, signs, or tests supporting a diagnosis of peripheral neuropathy plus the presence of a callus; or
    e. The specifics about poor circulation in the feet – e.g.., a diagnosis of venous or arterial insufficiency or symptoms, signs, or tests documenting one of these diagnoses. A diagnosis of hypertension, coronary artery disease, or congestive heart failure or the presences of edema are not by themselves sufficient.
3. I also need a Detailed Written Order signed and dated which we will fax over to you after we see your patient.

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DIABETIC FOOTWEAR PRESCRIPTION FORM

Patient Name: _____ Date of Birth: _____

(Please check items you are prescribing)

_____ Diabetic Extra Depth Shoes

_____ Custom Molded Inserts _____ Heat Moldable Inserts

_____ Custom Molded Shoes

SHOE MODIFICATIONS

_____ Shoe Lift (Left Right)

_____ Rocker Sole (Left Right)

_____ Wedge (Medial Lateral) (Left Right)

_____ Other: _____

DIAGNOSIS: _____

ICD – CODE: _____ _____ _____ _____

_____ _____
Physician Signature Date

3500 6th Avenue
Altoona, PA 16602
814-944-0187 – Phone
814-942-1712 - Fax

130 McCracken Run Rd.
Suite 1
DuBois, PA 15801
814-371-8225 – Phone
814-371-8425 - Fax

2505 Green Tech Drive
Suite A2
State College, PA
814-235-5398 – Phone
814-235-6499 - Fax

Dear Dr.

Please see the enclosed forms to assist you so that we may provide diabetic footwear for the patient. Please note the following:

1) This must be a face to face office visit with a M.D. or a D.O
2) The office visit must have been within the last 5 months.
3) Clinical notes must indicate that the patient is being actively treated for their Diabetes Mellitus.
4) Diabetic foot evaluation & problems that are indicated on the Certifying Physician form must be included in clinical notes.

Thank you so much for your time and cooperation in helping us provide diabetic footwear for your patient.

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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
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: _____

DIABETIC FOOT EXAM

Please circle all that apply

Patient's Name_____ **Date of Exam**_____

Primary Diagnosis

Diabetes Mellitus with Diabetic Polyneuropathy

Diabetes Mellitus with Peripheral Angiopathy

Diabetes Mellitus with Foot Ulcer

Foot Deformity

Bunion LT RT

Hammer toes LT 1 2 3 4 5

Hammer toes RT 1 2 3 4 5

Other _____

History of Partial or Complete Amputations

Foot LT RT

Below Knee LT RT

Above Knee LT RT

Toes LT 1 2 3 4 5

Toes RT 1 2 3 4 5

Metatarsals LT 1 2 3 4 5

Metatarsals RT 1 2 3 4 5

Other RT_____ LT_____

History of Calluses

Sub Metatarsal LT 1 2 3 4 5

Sub Metatarsal RT 1 2 3 4 5

Toes LT 1 2 3 4 5

Toes RT 1 2 3 4 5

Heels LT 1 2 3 4 5

Heels RT 1 2 3 4 5

Other RT_____ LT_____

History of Ulcers

Sub Metatarsal LT 1 2 3 4 5

Sub Metatarsal RT 1 2 3 4 5

Toes LT 1 2 3 4 5

Toes RT 1 2 3 4 5

Heels LT 1 2 3 4 5

Heels RT 1 2 3 4 5

Other RT_____ LT_____

Neurological Exam

Vibration Perception

Diminished Normal

Loss of Sensation

Diminished Normal

Sharp/Dull

Diminished Normal

Physician Signature:

_____

Physician name: (printed – must be MD or DO)

_____

Date: _____