SPEARS
Prosthetics & Orthotics

722 N. White Station Rd. Memphis, TN. 38122
(901) 763-6999 call/text eFax (901) 682-9062
SpearsPandO.com

Your doctor has given you a prescription for Diabetic/Therapeutic shoes and inserts. The following forms must be filled out by your ordering and diabetic physician. In order for your insurance to pay you will need to have been seen by your ordering and diabetic physician within the last 6 months and the Statement of Certifying Physician for Therapeutic Shoes must be signed and filled out within 3 months.

To qualify for your insurance to pay a patient's ordering physician and treating diabetic physican must fill out and sign
the following forms.

Ordering Physician:

1. Your ordering physician must fill out and sign the **Standard Written Order** along with his/her office notes.

Diabetic Physician:

1. Your Diabetic Physician if different from your ordering physician must fill out and sign the Statement of Certifying Physician for Therapeutic Shoes along with his/her office notes.

Once these forms are filled out and signed by your physician(s) and you have your physician's notes then it's time for you to be scheduled for your measuring appointment and selecting your shoes. Please call our office at 901-763-6999 and select 0 for the appointment desk, for the first available appointment. We look forward to seeing you and starting your journey with us.

Sincerely,

Spears Prosthetics & Orthotics

* If you have any questions please contact our billing department at 901-763-6999 ext 106

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Standard Written Order for Therapeutic Shoes and Inserts

Please fill out the top part. Your doctor will fill out the bottom part.

Patient Name_____D.O.B._____

Address:_____City:_____

State:_____Zip Code:_____Phone Number:_____

Provider of Service

Spears Prosthetics & Orthotics
722 N White Station Rd
Memphis TN. 38122
Phone # (901) 763-6999
Fax # (901) 682-9062
NPI 1316093388

Diagnosis (ICD-10):_____

_____

Item/Services: _____ A5500 (Diabetic Shoes) x2
_____ A5512 (Off the Shelf Inserts) x6
_____ A5513 (Custom Inserts) x2

_____L5000 (Toe Filler)
_____L2755 (Carbon Footplate)

Duration of Usage: 12 Months

Physician Signature:_____ Date:_____

Physician Name (Printed):_____NPI:_____

Address::_____Phone #:_____

Please ensure that this form is completed only by the Physician. No stamped signature permitted.

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

MBI: _____

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: _____

revised April 2018

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all of the following criteria are met:

The beneficiary has diabetes mellitus (Reference diagnosis code section below); and

The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:

Previous amputation of the other foot, or part of either foot, or

History of previous foot ulceration of either foot, or

History of pre-ulcerative calluses of either foot, or

Peripheral neuropathy with evidence of callus formation of either foot, or

Foot deformity of either foot, or

Poor circulation in either foot; and

The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes. For claims with dates of service on or after 01/01/2011, the certifying physician must:

Have an in-person visit with the beneficiary during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and

Sign the certification statement (refer to the Policy Specific Documentation Requirements section below) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

In order to meet criterion 2, the certifying physician must either:

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.

The requirement that the in-person visit(s) be within 6 months prior to delivery of the shoes/inserts is effective for claims with dates of service on or after 1/1/2011.