SPEARS
Prosthetics & Orthotics

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

Welcome to Spears Prosthetics and Orthotics. Your doctor has now written you a prescription for diabetic shoes and inserts. Please read and follow the Medicare explanation for what you need to do before your insurance, will pay for your diabetic shoes and diabetic inserts. If you have any questions, please give us a call at 901-763-6999. Once you get all your paperwork needed for your insurance to pay, please contact our office to set up your measurement appointment. We look forward to hearing from you and starting your journey with you.

Thank You,

Spears Prosthetics & Orthotics

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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. For your insurance to pay you will need to be 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 physician 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 number 901-763-6999 and select 0, for the appointment desk, for our first available appointment. We look forward to seeing you and starting your journey with us.

Sincerely,

Spears Prosthetics & Orthotics

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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 units _____L5000 (Toe Filler)
_____A5512 (Heat and Molded Inserts) x 6 units _____L2755 (Carbon Footplate)
_____A5513/A5514 (Custom Inserts) x2 units

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

PLEASE FAX TO:

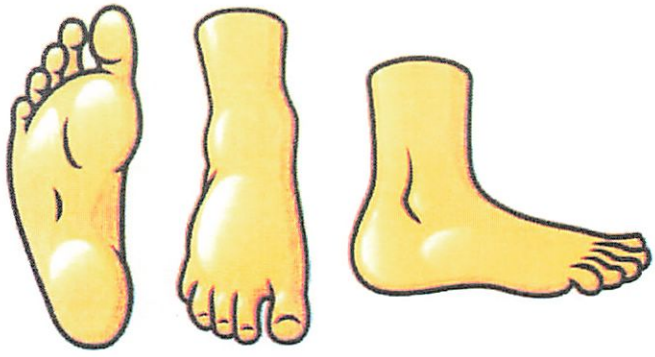
DIABETIC FOOT EXAM

Patient Name:		MBI#:		DOB:	

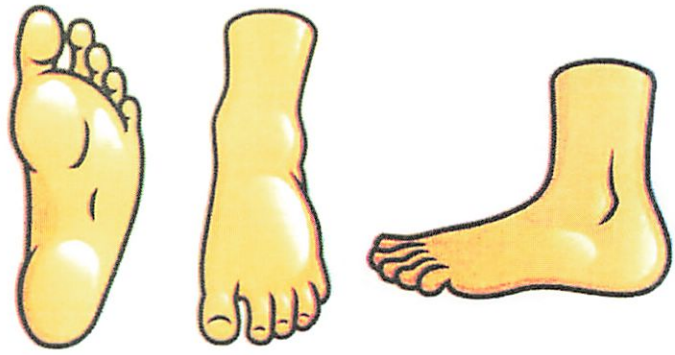
Patient concerns and history:

Diabetic foot exam performed today to identify risk and need for therapeutic shoes and inserts:

RIGHT FOOT



LEFT FOOT



Note deformities on the images above using the symbol key below:

A: Amputation **B**: Bunions **C**: Callus **H**: Hammer Toes **R**: Redness **S**: Swelling **W**: Wound/Ulcer

Amputation: ☐ Left ☐ Right
Bunions: ☐ Left ☐ Right
Callus: ☐ Left ☐ Right
Hammer Toes: ☐ Left ☐ Right
Redness: ☐ Left ☐ Right
Swelling: ☐ Left ☐ Right
Wound/Ulcer: ☐ Left ☐ Right

Cognitive Awareness: ☐ Normal ☐ Abnormal
Fat Pads: ☐ Normal ☐ Abnormal
Foot Color: ☐ Normal ☐ Abnormal
Range of Motion: ☐ Normal ☐ Abnormal
Skin Temperature: ☐ Normal ☐ Abnormal
Skin Integrity: ☐ Normal ☐ Abnormal

DPM Signature:		DPM Name: (Printed)		Date:	

***Certifying Physician/Practitioner Acknowledgement:** I am the MD/DO/NP supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I agree with the above foot examination conducted by this patient's podiatrist, or eligible prescriber, and agree with the findings and the need for the products listed. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and inserts.

Primary Care Signature: (MD, DO or NP ONLY)		Date:	
Primary Care Name: (Printed)		NPI:	
Primary Care Address:			

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.