Shoe Fit Rx
2504 W. 46th Street
Sioux Falls, SD 57105
Phone 605-359-8554
Fax 605-525-6025

Thank you for your referral and support of Shoe Fit Rx. We have been asked to provide a diabetic foot evaluation for your patient who is at 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 patient's primary Care Physician (PCP), Endocrinologist, or Wound Care Physician are required to certify that the patient meets one or more of the qualifying conditions listed on the statement of Certifying Physician (attachment 1).

To satisfy this requirement, we ask that you please complete the attached documents, send the most recent Diabetes Management Exam Note(s) including the foot exam, and a copy of the patient's insurance card(s).

Documents Needed to Complete Evaluation

- ❒ Diabetes Management Office Note including Foot Exam
  - ❒ Within the last 6 months
- ❒ Prescription for Diabetic Shoes and Inserts
  - ❒ Complete, Sign, and Date by who performed the foot exam, MD, DO, CNP, PA, CNS, or DPM
- ❒ Statement of Certifying Physician
  - ❒ Complete, Sign, and Date by MD or DO only
- ❒ Insurance Card(s)
- ❒ Fax the above to Shoe Fit Rx at 605-525-6025

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PRESCRIPTION FOR THERAPEUTIC SHOES AND INSERTS

Patient Name: _____

DOB: _____

Quantity (Circle Quantity)	HCPCS Code	Description
1	A5500	Diabetic Extra-Depth Shoes, Pair
1 2 3	A5512	Prefabricated Heat Moldable Inserts, Pair
1 2 3	A5514	Custom Fabricated Inserts, Pair

Other: _____

Diagnosis: Diabetes Mellitus Type I / Type II and _____

_____(qualifying foot condition(s).

Therapeutic Objectives:

- Prevent ulceration and other pedal complications
- Distribute weight, balance, and plantar pressure

Duration Usage: 12 Months

Provider Signature: _____ Date: _____

Provider Name: _____ NPI: _____

Provider Address:

_____
Street City State Zip Code

*Please ensure this form is completed by the **MD, DO, CNP, PA-C, CNS, DPM** that performed the patient's Foot Exam.*
No stamped signatures are permitted or accepted.

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STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES AND INSERTS

Patient Name: _____

DOB: _____

Please complete the Statement of Certifying Physician for the patient listed above so that we may provide them with therapeutic shoes and inserts.

To qualify for Medicare reimbursement, it is required that the patient's primary Care Physician (PCP), Endocrinologist, or Wound Care Physician certify that the patient meets one or more of the conditions listed below.

I certify that all the following statements are true:

1. This patient has diabetes mellitus.

   Type I ICD-10 Code(s): _____ Type II ICD-10 Code(s): _____

2. This patient has one or more of the following conditions (mark all that apply):

   - ○ History of partial or complete amputation of the foot
   - ○ History of previous foot ulceration
   - ○ History of pre-ulcerative callus
   - ○ Peripheral neuropathy with evidence of callus formation
   - ○ Foot deformity
   - ○ Poor circulation

   Please make certain these condition(s) are consistent with and supported by the clinical findings noted in the patient's Diabetes Management Exam Notes and/or Foot Exam.

3. I am treating this patient under a comprehensive plan of care for diabetes.

4. This patient needs special shoes and inserts to help prevent complications resulting from diabetes.

Provider Signature: _____ Date: _____

Provider Name: _____ NPI: _____

Provider Address:

_____
Street City State Zip Code

*Please ensure this form is completed by the **MD or DO** only. No stamped signatures are permitted or accepted.*