

Vassel's

Comfort shoes and Custom Insoles
10421 West Florissant Ave St. Louis, MO 63136
(Phone): 314-471-0059
FAX #: 314-474-0208 OR 314-471-0059

WEBSITE: VASSELS.COM

Diabetic Shoe Request (*MEDICAID ONLY*)

To: JAQUAN VASSEL, BOCPD	Date: _____
Fax: _____	Re: _____
From: _____	DOB: _____

Pages (including cover sheet): 3

Please complete the following:

STEP 1.

- **COMPLETE THE MEDICAID PRE-CERTIFICATION FOR SHOES AND INSERTS**
***(INSRTUCTIONS ON SECOND PAGE)**

STEP 2.

- **COMPLETE THE "PRESCRIPTION"**

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Instructions for Pre-Certification of Diabetic Shoes and Inserts for Missouri Medicaid Beneficiaries with Diabetes

Dear Doctor,

TO PRE-CERTIFY YOUR PATIENT:

- You can call MO HealthNet @ 800-392-8030 then choose "Option 2" and inform the representative that you want to Pre-Certify diabetic shoes AND inserts.

OR

- You can also complete the pre-certification online at www.cyberaccessonline.net
- Please enter the pre-certification numbers below (**THAT ARE GIVEN TO YOU BY MEDICAID**) and fax to 314-474-0208. Feel free to call if you have questions.

Pre-certification number for the shoes: _____ (Code A5500)

Pre-certification number for the inserts: _____

Please indicate if you certified: ___ heat molded inserts (A5512)
___ custom molded inserts (A5513)

Thank you,
Jaquan Vassel, BOCPD
Certified PEDORTHIST

Diabetic Shoe Prescription

Patient Name: _____

Address: _____

PHONE #: _____

DOB: _____

Per Statement of Certifying Physician, the patient has one of more of the following foot conditions:

<input type="checkbox"/> Previous Amputation	<input type="checkbox"/> Peripheral Neuropathy w/ callus	<input type="checkbox"/> Previous Ulceration
<input type="checkbox"/> Foot Deformity	<input type="checkbox"/> Pre Ulcerative Callus	<input type="checkbox"/> Poor Circulation in the Feet

The patient requires:

Diabetic Footwear, non-custom (A5500) - 1 pair (unless otherwise indicated)

With:

Non custom, heat moldable inserts (A5512) -3 pairs (unless otherwise indicated)

Or

Custom molded inserts (A5513) -3 pairs (unless otherwise indicated)

Physician Signature _____

Date: _____