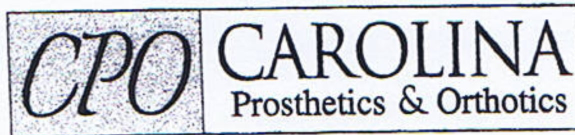

Dear Physician,

Attached please find a **Statement of Certifying for Therapeutic Shoes and a Prescription** for your approval and signature. Both a prescription and this Certification Statement are required by Medicare in order for us to treat and provide shoes and inserts for diabetic patients. Medicare guidelines now require the prescription to have the diagnosis, the diagnosis code and the duration of need to be signed by the patient's diabetic care manager. In order to comply with Medicare guidelines, we are sending the documents to you for completion.

Current Medicare guidelines allow each Medicare recipient, with a diagnosis of conjunction with certain related problems, to receive one pair of extra depth diabetic shoes and three pair of diabetic inserts each year. On behalf of this patient, we are requesting a prescription that is written in this way. If you should have any questions please feel free to call our office.

We appreciate your assistance in advance with helping us provide quality care to the patients in this community.

Sincerely,

Tommy McCrea, CPO

Professional Park • 110 Liner Drive • Greenwood, SC 29646
Phone (864) 942-7001 • Fax (864) 942-7008

Dear Patient,

Attached you will find a letter and a Statement of Certifying for Therapeutic Shoes and a Prescription for you Diabetic Physician to sign. Due to Medicare rules and regulations were are required to have this paper work signed before we can order your shoes. Please make an appointment with your physician to have this paper work signed. Once you have all documents signed please return to our office and we will then measure you for your diabetic shoes. If you have any questions, please feel free to contact our office. Thank you!

Carolina Prosthetics and Orthotics

Professional Park • 110 Liner Drive • Greenwood, SC 29646
Phone (864) 942-7001 • Fax (864) 942-7008

CAROLINA PROSTHETICS & ORTHOTICS

Professional Park
110 Liner Drive
Greenwood, SC 29646
Phone: 864-942-7001
Fax: 864-942-7008

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Name: ____

HIC#: ______________________________________

Circle all that apply:

I certify that one of the following statements is 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 UPIN: _________________________

HOURS
8:00 am - 5:00 pm
PLEASE CALL FOR
AN APPOINTMENT

Professional Park • 110 Liner Drive • Greenwood, SC 29646
Ph (864) 942-7001 • Fax (864) 942-7008

PATIENT'S NAME____________________ DATE __________

ADDRESS: DIABETIC

℞

DIABETIC SHOES

MULTI DENSITY INSERTS

CERTIFICATE OF MEDICAL NECESSITY

Dx Code: ________________

Dx: ____________________________

Reason for need: ________________________

Length of time needed: ______________________

____________________ ____________________
PHYSICIAN'S SIGNATURE PHYSICIAN'S NAME

____________________ ____________________
ADDRESS NPI