4 EASY STEPS ...

Dear Medicare Diabetic Patients,

In order to receive your Medicare benefits* for therapeutic footwear, you will need to schedule a foot exam with the physician that treats you for diabetes.

Take this booklet to your appointment and have your physician complete all required paperwork.

Thank you.

If you have any questions or concerns, please do not hesitate to contact your local Bio-Tech office or 1-800-Medicare (1-800-633-4227).

Bio-Tech
Prosthetics and Orthotics

**The forms within this booklet MUST be complete in order to receive your shoes and inserts as required by Medicare National Policy.*

In order for your patient to receive Medicare benefits:

1 **STEP ONE:** Please fill out the Statement of Certifying Physician, (Form #1). This form confirms that your patient meets the requirements to receive benefits; **1)** they have diabetes, **2) as well as** at least one of the six qualifying conditions listed on the statement. This form **must** be filled out by an M.D. or D.O.

2 **STEP TWO:** Please complete the Prescription for Diabetic Shoes and Inserts, (Form #2). This form can be filled out by an M.D., D.O., D.P.M., P.A., N.P., or Clinical Nurse Specialist. This is the basic prescription for diabetic shoes and inserts.

3 **STEP THREE:** Please complete the Comprehensive Diabetes Foot Examination, (Form #3). This form can be filled out by an M.D., D.O., D.P.M., P.A., N.P., or Clinical Nurse Specialist.

4 **STEP FOUR:** Please fax **all** forms, including all progress notes, from patient visit to the appropriate Bio-Tech office. These notes must state your patient has diabetes and the qualifying condition(s) must be clearly defined.

Comprehensive Diabetes Foot Examination **FORM #3**

Name: _____ D.O.B.: _____ Date: _____

I. Current History

1. Any change in the foot or feet since the last evaluation?
❑ Yes ❑ No
2. Current ulcer or history of a foot ulcer?
❑ Yes ❑ No

II. Foot Exam

1. Note foot deformities:
❑ Toe deformities ❑ Bunions ❑ Charcot foot
❑ Prominent metatarsal heads
❑ Amputation (Specify date, side and level.)

_____

2. Pedal Pulses
(Fill in the blanks with a "P" or an "A" to indicate present or absent.)

Posterior tibial:	Dorsalis pedis:
Left_____	Left_____
Right_____	Right_____

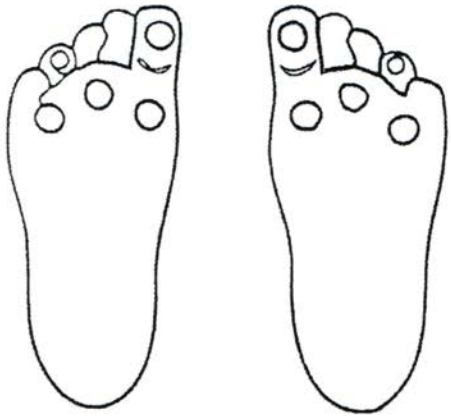
3. Is there evidence of callus formation?
❑ Yes ❑ No

4. Are there signs of pre-ulceration?
❑ Yes ❑ No

III. Sensory Foot Exam

Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 Semmes-Weinstein (10-gram) nylon monofilament and "-" if the patient cannot feel the filament.

(Measure, draw in and label the patient's skin condition)
(C) = Callus (R) = Redness (W) = Warmth
(F) = Fissure (S) = Swelling (U) = Ulcer
(M) = Maceration (PU) = Pre-ulcerative lesion
(D) = Dryness



IV. Risk Categorization (Check appropriate item.)

Low Risk Patient
All of the following:
❑ Intact protective sensation
❑ No prior foot ulcer
❑ No foot deformity
❑ Pedal pulses present
❑ No Amputation

High Risk Patient
One or more of the following:
❑ Loss of protective sensation
❑ Absent pedal pulses
❑ Foot deformity
❑ History of foot ulcer
❑ Previous Amputation

Physician Signature_____ Date: _____

Physician Printed Name_____

Statement of Certifying Physician **FORM #1**

Patient: _____ **ORDER/START DATE:** _____

Patient D.O.B. _____ Patient Phone: _____

Diagnosis (ICD-10 E08.00-13.9): _____ _____

Date of last OV Diabetes management addressed: _____
(must be within 90 days prior to signing CMN)

❑ Yes ❑ No This patient has diabetes mellitus

❑ Yes ❑ No **QUALIFYING CONDITIONS:** I have diagnosed that this patient has one or more of the following conditions*: ***(Check all that apply)***

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

**** These conditions are CLEARLY stated in my notes.***

❑ Yes ❑ No I am treating this patient under a comprehensive plan for care of his/her diabetes.

❑ Yes ❑ No This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

❑ Yes ❑ No This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

P.A. or N.P. Signature: _____

Physician Signature*: _____
**THIS FORM MUST BE SIGNED BY M.D. EVEN IF SIGNED BY P.A./N.P.*

Physician Name (Printed): _____

NPI #: _____ Date: _____

Physician Phone: _____

Physician Address: _____

_____

All forms and patient notes can be faxed to your local Bio-Tech office:
Greensboro: 336-333-9083 Winston-Salem: 336-768-3468 High Point: 336-889-7662

Prescription For Diabetic Shoes and Inserts **FORM #2**

Patient: _____

Patient D.O.B. _____ Patient Phone: _____

1) Type of shoes prescribed (check):

- ❑ Extra Depth (A5500) - 1 pair, unless otherwise noted
- ❑ Custom Molded (A5501) - Nature and severity of deformity must be documented in physician's notes for eligibility.

2) Type of inserts prescribed (check one):

- ❑ Heat Moldable (A5512)
- ❑ Custom Fabricated (A5513)

ICD Notes and/or Special Instructions:

_____

_____

_____

_____

_____

Physician Signature: _____
MUST BE AN M.D., D.O., D.P.M., P.A., N.P. OR CLINICAL NURSE SPECIALIST

Physician Name (Printed): _____

NPI #: _____ Date: _____

Physician Phone: _____

Physician Address: _____

_____

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