SCHUCKERT SHOES
607 LOUIS DRIVE, SUITE A-2 WARMINSTER, PA 18974
P-215-794-2600 F-215-794-2624

**DATE:**_____

**STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR/CERTIFICATE OF MEDICAL NECESSITY**

THIS FORM MUST BE FILLED OUT **COMPLETELY!**!!!

**ATTENTION:**_____

**(Please fax back Completed Form & Supporting Patient Notes at your earliest convenience.)**

Patient Name:_____ DOB___/___/___ Phone #_____

**Medicare #:**_____

**PLEASE NOTE**: The Certifying Physician must be either a M.D or D.O to comply with Medicare Regulations.

1. **This patient has diabetes mellitus:**

   IC10 Code:_____

2. **The patient has one or more of the following: (Please check all that apply)**

| | | | |
|---|---|---|---|
| ____ | **L84** Pre-Ulcerative calluses | ____ | **E11.40** Neuropathy Diabetes Type II w/Callus |
| ____ | **M21.969** Foot Deformity | ____ | **E10.40** Neuropathy Diabetes Type I w/Callus |
| ____ | **H05.359** Exostosis | ____ | **E11.51** Poor Circulation Diabetes Type II |
| ____ | **M21.61** Bunion | ____ | **E10.51** Poor Circulation Diabetes Type I |
| ____ | **M20.40** Hammertoe | ____ | **Z89.9** Complete or partial Amputation of foot |
| ____ | **Z86.31** History of previous Ulcer (foot) | | |

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

4. This patient requires extra depth shoes with special inserts (heat molded or custom fabricated) because of his/her diabetes.

5. By signing this statement, I certify that all of the above statements are true.*

Physician Name_____ Date Signed_____

Physician Signature_____ NPI#_____

Primary Care Office Address:_____

_____

**Patient Objectives**: To transfer forces from high to low pressure areas, provide protection for the insensitive diabetic foot, absorb shock, reduce shear, and maximize comfort.

**PRESCRIPTION:**

**PATIENT REQUIRES:**

**_____1 PAIR (2 units) Non-Custom Diabetic Footwear (A5500) &**

**_____3 PAIR (6 units) Heat Moldable Inserts (A5512) or**

**_____3 PAIR (6 units) Custom Molded Inserts (A5513) or Custom Fabricated Inserts (K0903)**

**Please retain a copy of this form in your patient's records.**
*** It is important to note that even though you may complete and sign this letter attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you have seen the patient in the last 6 months and are managing your patient's diabetes and that one of the conditions listed above is present. If requested by the supplier, you must provide those records.**

# MEDICAL RECORDS DOCUMENTING OFFICE VISIT FOR DIABETIC SHOES & INSERTS

**Patient's Name:** _____ **Patient's Date of Birth:** _____

**Date of Last Office Visit:** _____

**Physician Name:** _____ **Physicians Tel. Number:** _____

**Physician Address:** _____ **Physician NPI:** _____

_____

Peripheral Neuropathy:
- ❑ Yes
- ❑ No

Poor Circulation:
- ❑ Yes
- ❑ No

Callus Formation:
- ❑ 0 - Superficial
- ❑ 1 - Deep
- ❑ 2 - Ulcer

Charcot Arthopathy:
- ❑ Active
- ❑ HX
  - o R / L – Phalanges
  - o R / L – Forefoot
  - o R / L – Midfoot
  - o R / L – Hindfoot
  - o R / L – Other

Ulcer Grade:
- ❑ Intact Skin
- ❑ Superficial
- ❑ Tendon or Bone
- ❑ Abscess or Osteo
- ❑ Foot Gangrene
- ❑ Gangrene

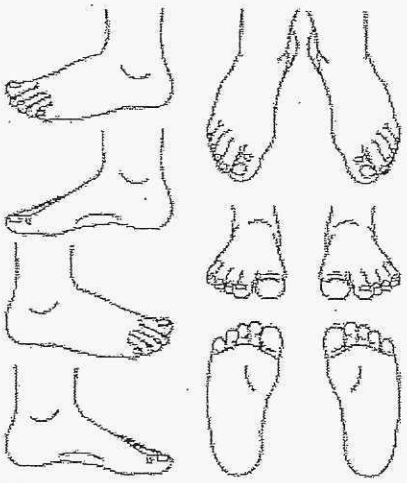
Additional Complications:
- ❑ Dialysis
- ❑ Vascular Impairment
- ❑ Retinopathy
- ❑ Proprioception
- ❑ Dermatological Breakdown
- ❑ Fungal Nail

Additional Deformities:
- ❑ Bunions
- ❑ Hammer Toe
- ❑ Claw Foot
- ❑ Amputation Toe / Foot
- ❑ Misc: _____

**Label Skin Conditions**

(Measure, Draw, & Label the Patient's skin condition using the key & foot diagram below)

1 = Warmth
2 = Fissure
3 = Swelling
4 = Pre-Ulcerative Lesion
5 = Maceration
6 = Dryness
7 = Callus
8 = Ulcer



| Monofilament Response: | Ulcer: | Deformity: |
|---|---|---|
| ❑ +5.07 (10gm) | Yes or No | Yes or No |
| ❑ -5.07 (10gm) | Yes or No | Yes or No |
| ❑ -6.10 (10gm) | Yes or No | Yes or No |

**Physician's Signature** **Date Signed**

**Physician's Printed Name**

If the above medical records from the office visit are completed by a Podiatrist, PA, NP, or CNS, it **MUST BE SIGNED** & dated by an **MD or DO** indicating agreement with the above evaluation. By signing this document, I am hereby agreeing with the above assessment.

**MD or DO Signature** **Date Signed**

**MD or DO Printed Name**