MT. STERLING HEALTHY FOOT CENTER
570 INDIAN MOUND DRIVE
MT. STERLING, KY 40353
(859)498-3141

PHYSICIAN NOTES ON QUALIFYING CONDITION(S) FOR THERAPEUTIC SHOES

[redacted] FAX TO: 859-498-2434

PATIENT NAME: _____ **DATE OF BIRTH:**_____ **PHONE NUMBER:**_____

TREATMENT PLAN
Start Date: _____ Duration of DM: _____

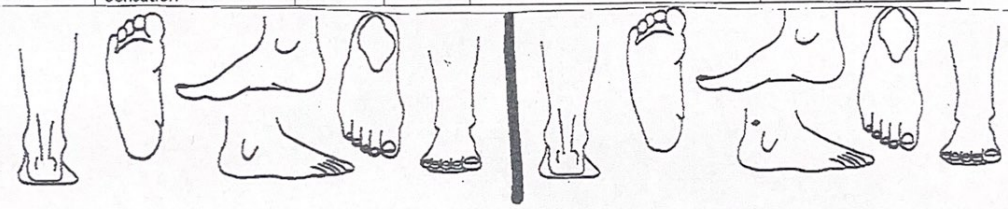
PLAN OF CARE
[ ] Diet [ ] Meds [ ] Oral [ ] Injection

Diabetes Type: [ ] Type I, Controlled [ ] Type II, Controlled [ ] Type I, Uncontrolled [ ] Type II, Uncontrolled

Name of MD/DO Supervising DM*:_____ **Date of last FBS:** _____
(Please sign Certifying Physician Acknowledgement below)

Physical Exam:

Neurological (Use Y or N)	Right	Left	Vascular (Circle appropriate level)	Right	Left
Loss of Vibration Perception			Dorsalis Pedis (3=Normal)	0 1 2 3 4	0 1 2 3 4
Loss of Protective Sensation			Posterior Tibial (3=Normal)	0 1 2 3 4	0 1 2 3 4



RIGHT FOOT LEFT FOOT

Note any calluses, bunions, swelling, redness, deformities, or amputations using the symbol key below:
C-Callus **B**-Bunion **S**-Swelling **R**-Redness **D**-Deformity **HC**-Hammer/Claw Toe **A**-Amputation **W**-Wound

***Certifying Physician Acknowledgement:**
I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus.
I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings.
I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and insoles.

Physician Signature:_____ **Date:** _____

Physician Name Printed:_____ **Physician NPI:**_____

Note: Shoes must be dispensed within 6 months from when diabetes care was discussed by Certifying Physician with patient.

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Prescription for Therapeutic Shoes and Inserts

PLEASE FAX TO: 859498-2434

Patient Name:_____ **HICN:**_____

Date Of Birth:_____ **Patient Phone #:**_____

Prescriber Name:_____ **Prescriber Phone #:**_____

Quantity (Please check)	**HCPC Code**	**Description**
1 [ ]	A5500	Diabetic Depth Shoes, pair
3 [ ] 2 [ ] 1 [ ]	A5512	Prefabricated inserts pairs—multiple density
	OR	
3 [ ] 2 [ ] 1 [ ]	A5513	Custom-molded inserts—Multiple density, molded to model of patient's foot. Medicare allows up to three pairs of inserts per year.

Primary Diagnosis Code: _____ _____ ____.____ ____

Please confirm that the entered Diagnosis Codes match your charting documentation.
(Example: E11.9, E10.9, E11.65, E11.40, E10.40, E11.51, E10.51)

Duration of usage: 12 months

Prescriber Signature:_____ **Date:**_____

Prescriber Name (Printed):_____ Prescriber NPI#: _____

Must be the MD, Do or other eligible prescriber who is actively treating patient's diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)

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Statement of Certifying Physician for Therapeutic Shoes

PLEASE FAX TO: 859-498-2434

Patient Name: _____ **HICN:** _____

When completing and signing this form, please make certain that the following checked condition(s) are the same as your determined diagnosis indicated on the Physician Notes on Qualifying Condition.

(Note: Shoes must be dispensed within 3 months of date Certifying Statement signed by physician)

I certify that all of the following are true:

Diabetes Type:
[ ] Type II, Controlled
[ ] Type I, Controlled
[ ] Type II, Uncontrolled
[ ] Type II, Uncontrolled

Primary Diagnosis:
[ ] Diabetes with neurological manifestations
[ ] Diabetes with peripheral circulatory disorder
[ ] Diabetes without neurovascular manifestations and with structural deformity

Foot Deformity
[ ] Arthropathy associated with neurological disorders
[ ] Bunion
[ ] Claw toe
[ ] Hallux rigidus
[ ] Hallux valgus
[ ] Hammer toe
[ ] Unspecified deformity of ankle and foot, acquired
[ ] Unspecified acquired deformity of toe

History of partial or complete amputation of the foot
[ ] Lower limb amputation, foot
[ ] Lower limb amputation, great toe
[ ] Lower limb amputation, lesser toe(s)

History of pre-ulcerative callus
[ ] History of pre-ulcerative callus

History of previous foot ulceration
[ ] Ulcer of heel and midfoot
[ ] Ulcer other part of foot

Peripheral neuropathy with evidence of callus formation
[ ] Neuropathy in diabetes

Poor circulation/PAD
[ ] Atherosclerosis of the extremities with intermittent claudication
[ ] Atherosclerosis of the extremities with ulceration
[ ] Atherosclerosis of the extremities, unspecified
[ ] Peripheral angiopathy
[ ] Peripheral vascular disease unspecified

Acknowledgement Statement:
I am managing and treating this patient's diabetes under a comprehensive plan of care. This patient requires diabetic shoes and heat-molded inserts to help prevent ulcers and further complications.

Physician Signature:_____ **Date:**_____
Physician Name (Printed): _____**Physician NPI#**_____
(MUST BE THE MD OR DO WHO IS ACTIVELY TREATING THE PATIENT'S DIABETES)
Physician Address:_____ **Physician Phone #:**_____
_____