MEMORANDUM

DATE:

TO:

FROM: DR. RUSSELL W. ROWAN

SUBJECT: DIABETIC FOOTWEAR DOCUMENTATION REQUEST

DATE:

PATIENT: **DOB:**

I am writing to request your assistance in providing the above patient with diabetic footwear, as provided under the Therapeutic Shoes for Persons with Diabetes Act (TSPD). In order to qualify for Medicare reimbursement, your certification that they meet certain conditions is required. I am asking you to review, complete the attached form, and submit with the accompanying office note. The patient must be seen and evaluated within six (6) months.

Should you have any questions or concerns, do not hesitate to contact our Diabetic Shoe Coordinator, Annarah, at 850.878.6998 x324.

CONFIDENTIALITY NOTICE

Information in this fax is intended for the use of the designated recipient(s) named above. This message may contain information of a physician-patient communication and as such is privileged and confidential. If the reader of the message is not the intended recipient or his agent, you are hereby notified that you have received this message in error. Any review, dissemination, distribution or copy of this document if received in error is prohibited. Should you receive this communication in error, please notify this office immediately at the number listed above. Thank you.

STATEMENT FOR CERTIFYING PHYSICAN & MEDICAL NECESSITY FOR DIABETIC SHOES

I, Dr. Russell W. Rowan, am writing to request a completion of the information below to certify you agree with my diagnosis and the need for therapeutic shoes and inserts. To qualify for reimbursement, your certification is *required*. It is important to note there must be documentation in your medical records indicating you are managing the patient's diabetes and one of the conditions listed below is present.

Patient Name: ______________________________ **DOB:** ______________

Insurance/Policy #: ____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD-10;
   ________ Diabetes Type II (Non-insulin Dependent); E11.9
   ________ Diabetes Type I (Insulin Dependent); E11.49

2. This patient has one (or more) of the following conditions:
   ________ History of partial or complete amputation of the foot.
   ________ History of previous foot ulceration.
   ________ History of pre-ulcerative callus.
   ________ Peripheral neuropathy with evidence of callus formation
   ________ Foot deformity
   ________ 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.

5. This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physician's Signature: ________________________________ Date: ____________________

Printed Name (MD/DO): ________________________________ NPI: ____________________

Physician's Address: ____

PLEASE RETURN COMPLETED FORM and *INCLUDE OFFICE NOTE* VIA FAX TO: 850.656.9293

Thank you for your cooperation in assisting our mutual diabetic patient! Should you have any questions or concerns, do not hesitate to contact our office at 850.878.6998 x324. Thank you.