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PROSTHETICS & ORTHOTICS *restoring independence | renewing lives*
Meridian | Nampa
T|208-342-4659 F|208-342-8211
www.brownfieldstech.com

Dear Physician,

Our mutual patient would like to receive diabetic footwear. In order for insurance to consider coverage, the following criteria must be met and the required documentation must be on file:

Criteria

- An M.D. or D.O. must be managing the patient's diabetes and certify diabetic footwear is medically necessary.
- The M.D. or D.O. managing the patient's diabetes must document the patient has one or more of the qualifying conditions:
    - Previous partial amputation of one or both feet or complete amputation of one foot
    - Current or previous foot ulceration
    - Current or previous pre-ulcerative callus
    - Peripheral neuropathy *with* evidence of callus formation
    - Foot deformity
    - Poor circulation

Required documentation

1. A dispensing prescription (dated on or after appointment with MD or DO)
2. A copy of office visit chart notes within past 6 months from the MD or DO managing the patient's diabetes that discusses diabetic management and treatment.
3. A diabetic verification form, completed by MD or DO managing the patient's diabetes, indicating the patient has one or more of the qualifying conditions listed under # 2 of form. NOTE: The diabetic verification form is *not* sufficient by itself. Rather, office visit chart notes must support the selected qualifying condition(s) with detailed examples.

Any documents from a DPM, NP, PA or other healthcare provider must be co-signed by the MD or DO treating the patient's diabetes.

Please visit the following links for more information:

https://med.noridianmedicare.com/web/jddme/policies/physician-resources/therapeutic-shoes

https://med.noridianmedicare.com/documents/2230715/2240923/Therapeutic+Shoes+for+Persons+with+Diabetes.pdf/b38e068a-ceef-481b-9ae5-1f4794f1a675

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Patient: _____ DOB: _____

Rx Select Any Applicable:

- ☐ A5500 – Diabetic Shoes _____ pair(s)
- ☐ A5513 – Diabetic Shoe Inserts _____ pair(s)

- ☐ Lifetime/Daily Usage on item(s) listed above

ICD-10 code(s): _____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Physician's Phone: _____ Fax: _____

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Diabetic Verification Form

Patient Name (Last, First, MI)	**Patient DOB**

The following **must be completed by M.D. or D.O.**

The physician listed below certifies that all the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following qualifying conditions (check all that apply):

NOTE: the qualifying condition(s) selected below must be well documented in office visit chart notes

- ☐ Previous partial amputation of one or both feet or complete amputation of one foot
- ☐ Current or previous foot ulceration
- ☐ Current or previous 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 therapeutic shoes (extra depth or custom-molded) for his/her diabetes.
5. I have seen this patient within the past 6 months.

Physician's Printed Name	**Physician's NPI**

Physician's Address

Physician's Phone	**Physician's Fax**

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient and are deemed medically necessary.

_____ _____

Physician's Signature **Date**