

## **Medicare Requirements for Diabetic Shoes Annually**

- Complete the attached certifying statement, exam form, and return with MD signed clinical notes.
  - Patient must have one or more of the qualifying conditions listed.
  - MD/DO has to be treating the patient under a comprehensive plan of care and produce medical records that justify the necessity.
- Must perform a diabetic foot exam within 6 months of shoe delivery.
  - Treating MD/DO must sign off on clinical notes from the foot exam.

Once all necessary documentation is received, the patient will be scheduled to be measured for diabetic shoes and inlays.

If there are any questions please call the office.

Thank you for your cooperation,

**Buckner Team** 

Buckner Prosthetics/Orthotics 2089 Lakeland Dr. Jackson, MS. 39216 601-944-1130 P/ 601-355-7476 F

OR GIVE THIS AND YOUR PATIENT NOTES BACK TO THE PATIENT. THANK YOU	FAX THIS AND YOUR PATIENT NOTES TO THE NUMBER ON THE BACK OF BROCHURE
Physician Address:	Physician Address:
Physician Phone:	Physician Phone:
NPI #: Date:	NPI #: Date:
Physician Name:	Physician Name:
Physician Signature:	Physician Signature:
	5) This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.
	<ol> <li>This patient needs special shoes (extra depth or custom molded) because of his/her diabetes.</li> </ol>
	<ol> <li>I am treating this patient under a comprehensive plan for care of his/her diabetes.</li> </ol>
Custom Fabricated (A5513) - 3 pairs, unless otherwise noted ICD Notes and/or Special Instructions:	Foot deformity Peripheral neuropathy with evidence of callus formation History of pre-ulcerative callus History of previous foot ulceration History of partial or complete amputation of the foot
<ul><li>Type of inserts prescribed (check one):</li><li>Heat Moldable (A5512) - 3 pairs, unless otherwise noted</li></ul>	2) QUALIFYING CONDITIONS: I have diagnosed and am including my notes showing that this patient has one or more of the following:
Extra Depth (A5500) - 1 pair, unless otherwise noted	Type II Type I
1) Type of shoes prescribed (check):	1) This patient has diabetes mellitus:
Patient D.O.B.: Patient Phone:	Patient D.O.B.: Patient Phone:
Patient:	Patient:
Prescription for Diabetic Shoes and Inserts	statement of Certifying Physician

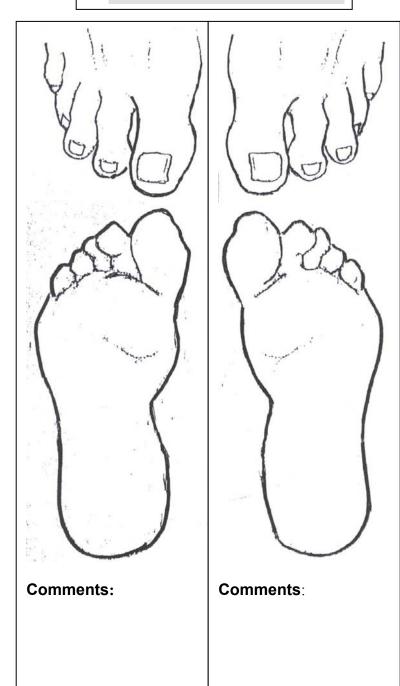
(TEAR OFF HERE FOR FAXING)

# **ANNUAL DIABETES FOOT EXAM FORM**

This is part of a comprehensive plan to treat this patient's diabetes.

### Note placement of

- calluses,
- pre-ulceration areas,
- ulceration areas, or
- areas lacking sensitivity.



Right foot

Left foot

NAME:						
DOB:						
BOB.						
MR#:						
*Circle or check findings as they apply						
Hx of amputation?	ŀ	Righ	<u>it /</u>	Le	eft	
Hx of ulceration?						
Right: No Yes Da						
Left: No Yes Da			NIa	V		
Pt able to see bottom of fee			No	Yes		
Pt wearing properly fitting s	noes	?	No	Yes		
FOOT EXAM						
Foot exam WNL						
PAD exam WNL						
(If abnormal-cir	cle w	/hicl	n foot)			
Foot ulcer?	No	/	Right	/	Left	
Abnormal shape?	No	/	Right	/	Left	
Charcot foot?	No	/	Right	/	Left	
Toe deformity?	No	/	Right	/	Left	
Thick or ingrown toenails?	No	1	Right	/	Left	
Callus build-up?	No	/	Right	/		
Edema?	No	/	Right	/	Left	
Elevated skin temp?	No	/	Right	/	Left	
Decreased circulation?	No	1	Right	/	Left	
Loss of sensation?	No	/	Right	/	Left	
Muscle weakness?	No	/	Right	/	Left	
PERIPHERAL ARTERY DISEASE (PAD) SCREEN						
History of claudication?		No	Y	'es		
Pedal pulses present?		No	Y	'es		
Notes:						
Ankle Brachial Index (ABI)	obtai	ned	? No	Ye	es	
Results:						
NOTES:						
DEFENDAL MARKET						
REFERRAL MADE TO:						
To:						
Appt Date:						
Even Dete:						
Exam Date:						
Signature:						