



**Phone: (612) 334-3159 | Fax: (612) 746-1058**

154 Cobblestone Lane | Burnsville | MN | 55337

www.DAHLMEDICALSUPPLY.com

**Certified provider of: Anodyne, Apex, Orthofeet, New Balance, Propet & Ped-Lite**

Dear Doctor: \_\_\_\_\_

A patient of yours: First: \_\_\_\_\_ Last: \_\_\_\_\_ DOB: \_\_\_\_\_

Contacted us on \_\_\_\_/\_\_\_\_/\_\_\_\_ and is interested in getting diabetic shoes in 2023 from us:

## **Dahl Medical Supply**

**154 Cobblestone Ln.**

**Burnsville, MN 55337**

**Phone: (612) 334-3159**

They have indicated that they have seen you within the past 6 months and have asked that we fax you the proper information needed for diabetic footwear & orthotics in 2023

To justify the Therapeutic Shoe Bill's requirements, insurance requests that the medical records include the following **signed** documents:

1. Attached is a **SHOE PRESCRIPTION FORM** that can be signed by a (DPM, MD, DO, PA, NP or CNS)
2. Attached is a **STATEMENT of CERTIFYING PHYSICIAN** that can **ONLY** be signed by a (MD or DO)
3. Attached is a **LETTER OF MEDICAL NECESSITY FOR DIABETIC SHOES** that needs to be filled out and signed by the provider who signed the **STATEMENT of CERTIFYING PHYSICIAN** (MD or DO).
4. Please fax **FOOT EXAM & CLINICAL NOTES** that are **SIGNED** and dated by MD or DO only within the last 6 months. *(More information about this is on page 4 with an example of what's needed in notes).*

We understand this process is complicated and takes up much of your time and energy. If you have any questions about these forms, please get in touch with us at (612) 334-3159.

Please fax all paperwork back to Dahl Medical Supply at (763) 746-1058

Thank you,  
Dahl Medical Supply Staff

# Comprehensive Diabetic Intake Form

Required to satisfy Medicare requirement of an in-person visit to determine the need for diabetic shoes.

## Patient Information:

Title: Mr. Ms. Mrs Dr. Gender: M F  
First Name \_\_\_\_\_ Middle: \_\_\_\_\_ Last \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Primary? Yes | No  
Insurance Name: \_\_\_\_\_ ID: \_\_\_\_\_ Group Number \_\_\_\_\_  
Medical Assistance: PMI Number \_\_\_\_\_

***If patient has diabetes and Medicare or any other insurance, has he/she received shoes under the Therapeutic Shoe Program this calendar year? Yes | No***

***Which feet does patient have? Both | Left | Right***

## ***Certifying Physician Managing Diabetes Care***

Degree: MD | DO Approximate Patients Primary Care Provider Length: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

# Information Needed: 1 of 4 PAGES

## DIABETIC FOOTWEAR PRESCRIPTION FORM

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**(STEP 1 of 9): Primary Diagnosis: ICD-10: \_\_\_\_\_ (E08.00 - E11.9, E13.00 -E13.9)**

**(STEP 2 of 9): Check Prescribed Procedures:**



\_\_\_\_\_ One pair of extra depth shoes (A5500) with three pairs of custom-molded multi-density inserts (A5513)

**OR**

\_\_\_\_\_ One pair of extra depth shoes (A5500) with three pairs of heat-molded multi-density inserts (A5512)

**OR**

\_\_\_\_\_ Two pairs of extra depth (A5500) with three pairs of custom-molded multi-density inserts (A5513)

**\*\*Primary Medical Assistance Patients Only\*\***

**OR**

\_\_\_\_\_ Two pairs of extra depth (A5500) with three pairs of heat-molded multi-density inserts (A5512)

**\*\*Primary Medical Assistance Patients Only\*\***

**(STEP 3 of 9) Therapeutic Objectives - MUST CHECK 1:**



Prevent Ulceration and other pedal complications

Distribution weight, balance, and plantar pressure

**\*DPM, MD, DO, PA, NP or CNS are eligible to sign this form per insurance guidelines for Therapeutic Shoes \***

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Physician Signature **(NO STAMPS)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Address

\_\_\_\_\_  
Physician NPI #

\_\_\_\_\_  
12 Months

\_\_\_\_\_  
Duration of usage

\_\_\_\_\_  
Physician Fax #

\_\_\_\_\_  
Physician Phone

# Information Needed: 2 of 4 PAGES

## STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

\*\*\*\*\* In order for this form to be valid, it must be accompanied by detailed & **SIGNED** clinical notes regarding all indicated foot conditions. \*\*\*\*\*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I (M.D. or D.O) certify that all of the following statements are true:**


**(STEP 4 of 9):** This patient has diabetes mellitus. **ICD-10 Code:** \_\_\_\_\_  
(ICD-10 Diagnosis Code Required E08.00 - E11.9, E13.00 - E13.9)

**(STEP 5 of 9): This patient has one or more of the following conditions (check all that apply):**


- History of particular 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 **(If checked, must also have another condition marked)**

**\*\*Please make certain these condition(s) are consistent with and supported by CLINICAL findings noted and SIGNED in the patient's Diabetes Management Exam Notes and/or Foot Exam\*\***

**(STEP 6 of 9): Please fill in date below**

Not only am I treating this patient under a comprehensive plan of care for Diabetes, but I also recently saw this patient in person on \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. Their staged diagnosis has been personally documented by me in their file.  **Must be within six months of Prescription**

**(STEP 7 of 9): Please Check**

-   This patient needs special footwear (depth or custom-molded and/or inserts) because of their diabetic condition.
- The above information is documented in the patient's medical record, as indicated in the attached SIGNED clinical notes.

Per Medicare Rules 

Signature **(M.D. or D.O. *\*ONLY\** & NO STAMPS)**: \_\_\_\_\_ Date: \_\_\_\_\_

***\*PA-C's or ARNP's are NOT eligible to sign this form per insurance guidelines for Therapeutic Shoes \****

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

# Information Needed: 3 of 4 PAGES

## LETTER OF MEDICAL NECESSITY FOR DIABETIC SHOES

I \_\_\_\_\_ (MD or DO Name) am writing on behalf of my patient,  
\_\_\_\_\_ (Patient Name), to document the medical necessity of  
**diabetic shoes and inserts** for the treatment of \_\_\_\_\_ (specific diagnosis code:  
**E0.800 - E11.9, E13.00 - E.13.9**)

This patient needs diabetic shoes and custom and/or heat moldable inserts to protect at-risk feet. These prescribed shoes and inserts are medically necessary to maintain current ligament integrity, prevent further laxity, protect and support neuropathic feet, and provide an environment for healing.

\_\_\_\_\_ (MD or DO Signature).

**Treatment Rationale:** Please provide information on the treatment up to this point, the course of care, why the treatment and diabetic shoes are necessary, and how you expect it to help \_\_\_\_\_ (patient name).

---

---

---

---

In summary, diabetic shoes and custom and/or heat-melttable inserts are medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of these items.

Duration/Length of need: 12 Months

Sincerely, \_\_\_\_\_ (MD or DO Signature) \_\_\_\_\_ NPI Number  
No Stamps

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Information Needed: 4 of 4 PAGES



### (STEP 8 of 9):

Detailed SIGNED Clinical Notes Regarding the indicated foot conditions on RX PAGE 1 (Step 5) **MUST BE SIGNED BY THE MD OR DO WHO SIGNS THE PRESCRIPTION**

*More information is on page 5 Regarding clinical notes*



### (STEP 9 of 9):

Foot Exam Information that's performed by DPM, MD, DO, PA, NP or CNS

## Extremely Important

**WITHOUT ALL INFORMATION BEING FILLED OUT AND STEPS 8 & 9 FAXED BACK, MEDICARE & PRIVATE INSURANCE WILL DENY COVERAGE OF SHOES, AND THE PATIENT WILL BE RESPONSIBLE FOR THE COST OF SHOES & INSERTS.**



**Please Fax Back:**

Fax: (612) 746-1058



# IMPORTANT NOTE:

**In order for this form to be valid, it must be accompanied by DETAILED CLINICAL NOTES regarding the above indicated foot conditions!**

## GUIDELINE FOR CLINICAL NOTES

Dear Primary Care Doctor (or Endocrinologist):

Thank you for helping our mutual patient receive Diabetic Footwear. Medicare has for years required you to fill out and submit the Statement of Certifying Physician (SCP). However, over the last few years Medicare has increased the paperwork requirements on suppliers and referring physicians.

**WE MUST HAVE RECENT CLINICAL NOTES (WITHIN SIX MONTHS OF THE DATE YOU SIGN THE SCP) FROM YOU THAT SUPPORT THE FOUR MAJOR PORTIONS OF THE STATEMENT OF CERTIFYING PHYSICIAN. IF THE CLINICAL NOTES DO NOT SUPPORT THE STATEMENT OF CERTIFYING PHYSICIAN, THE STATEMENT IS RENDERED VOID.**

***YOU MAY SUBSTITUTE CHART NOTES FROM THE PATIENT'S PODIATRIST, BUT YOU MUST SIGN, DATE AND INDICATE AGREEMENT WITH THEIR FINDINGS.***

### CLINICAL NOTES GUIDELINES:

1. Must explicitly certify that the patient has diabetes and assign an applicable ICD-10 code. Results of tests, exams, and findings must be in the notes (i.e. blood glucose levels and A1c).
2. Must explicitly document a foot exam and one or more of the required conditions.

**THIS INCLUDES THE DETAILS OF TESTS, EXAMS, INSPECTIONS, FINDINGS, ETC. THAT WE'RE USED TO CONCLUDE THE CONDITION EXISTS.**

**Very Important**

**You may rely on the findings of other doctors, such as the patient's Podiatrist, but you must sign, date and make a note on their document indicating your agreement with their findings and then send that document along with the Statement of Certifying Physician that you have also completed, signed and dated.**

If you are noting a particular problem, such as a foot deformity, please specify which foot and the type and location of the problem (e.g. Patient has bilateral hammer toes #2-#5).

The following are commonly found foot conditions that place diabetic patients at increased risk and thus qualify them to receive therapeutic footwear through Medicare and other payers:

**Thank you for reading, filling out, and faxing back the proper information.**

**Fax Number: (612) 746-1058**

-Dahl Medical Supply

# Documentation Of In-Person Fitting

(Dahl Medical Use Only)

*Medicare provides coverage for shoes each calender year based on medical necessity and determination of need for replacement.*

If the patient has previously received **shoes** covered by Medicare, are they worn and in need of replacement?  Yes  No

If the patient has previously received **inserts** covered by Medicare, are they worn and in need of replacement?  Yes  No

## Shoe Size based on measuring device, fit of current worn shoes, and try-on

Previous Shoe Diabetic Shoe Style: \_\_\_\_\_ Size: \_\_\_\_\_ Width: \_\_\_\_\_

Shoes Being Worn During Visit: Style: \_\_\_\_\_ Size: \_\_\_\_\_ Width: \_\_\_\_\_

Measuring Device Size: \_\_\_\_\_ Width: \_\_\_\_\_

If fabricating custom inserts, please indicate the method of foot impression:

Foam  Scanner  Plaster

Customer comments regarding needs: \_\_\_\_\_

Observation of feet with socks off: Yes | No

Any Open Sores: Yes | No

## Diabetic Shoe Selection

**\*\*For Medicare Documentation\*\***

Style 1: Manufacture: \_\_\_\_\_ Style: \_\_\_\_\_  
Size: \_\_\_\_\_ Width: \_\_\_\_\_ Color: \_\_\_\_\_

Style 2: (MA Patient Only)

Manufacture: \_\_\_\_\_ Style: \_\_\_\_\_  
Size: \_\_\_\_\_ Width: \_\_\_\_\_ Color: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Fitter Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Fitter Signature: \_\_\_\_\_