

# FAX

<b>To:</b>	<b>From: Dahl Medical Supply</b>
<b>Fax:</b>	<b>Pages:</b>
<b>Phone:</b>	<b>Date:</b>

**Without all information, Dahl Medical CANNOT submit to patient's Insurance.**

## Medicare rules require that the medical records include the following:

- Diagnosis of Diabetes: **(E08 - E11.9, E13.00-E13.9)**
- Attested clinical notes showing you are treating the patient for their diabetic condition and that they need diabetic shoes.
- Foot Exam: Information must be performed by DPM, MD, DO, PA, NP or CNS but certified by MD or DO **(Foot Exam must take place within 6 months of certifying statement).**
- Documented clinical notes **(SIGNED BY MD or DO)** on the foot conditions you checked on the Statement of Certifying Physician form.

To meet this requirement – you may need to include notes from the patients’ DPM, Physician Assistant, Nurse Practitioner and/or Clinical Nurse Specialist. If you have any questions or concerns, please call us (612) 334-3159. ***Thank you in advance for your prompt attention to this request.***

Confidentiality Notice: This facimile contains confidential information which may be protected health information as defined by the federal HIPAA Privacy Rule or state law. This transmission is intended only for the individual or entity to which it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. The authorized recipient is mandated to maintain this information in a secure and confidential manner, and prohibited from using it for purposes other than intended, improper disclosure and required to either destroy the information after use or store the information in compliance with applicable laws or regulations.

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**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



  
**Diabetic  
Shoe  
Form**

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

**Medicare rules require the following signed documents:**

- Attached is a **SHOE PRESCRIPTION FORM** that can be signed by a (DPM, MD, DO, PA, NP or CNS)
- Attached is a **STATEMENT of CERTIFYING PHYSICIAN** that can **ONLY** be signed by a (MD or DO)
- Please fax **FOOT EXAM & CLINICAL NOTES** that are **SIGNED** and dated by MD or DO only within the last 6 months. **PLEASE NOTE:** Foot Exam & Clinical Notes must match **1 of the 6** conditions on **Steps 5 of 9** on the certifying physician statement and match the visit diagnosis signed on the certifying physician statement.

**(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 call us at (612) 334-3159.

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

Thank you,  
Dahl Medical Supply Staff

# Information Needed: 1 of 3 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 Phone Number

\_\_\_\_\_  
Physician Fax Number

# Information Needed: 2 of 3 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#: \_\_\_\_\_

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

# Information Needed: 3 of 3 PAGES



## (STEP 8 of 9):

Detailed **SIGNED** Clinical Notes Regarding the indicated foot conditions on RX PAGE 4 (Step 5 of 9) \***MUST BE SIGNED BY THE MD OR DO WHO SIGNS THE PRESCRIPTION\***

*\*More information is on page 7 Regarding clinical notes*



## (STEP 9 of 9):

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

**The exam must be in clinical notes and done within 6 months of certifying statement and attested by the MD OR DO**

*EXAMPLE* on page 6

**Extremely Important**

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

## CLINICAL NOTES GUIDELINES:

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

## EXAMPLE of Clinical Notes & Foot Exam

Must be signed and or attested by an MD or DO

### Assessment & Plan

- Type 2 diabetes mellitus with stage 1 chronic kidney disease, without long-term current use of insulin (H)
- The patient would like diabetic shoes, given his/her DM and his bunion on the RT foot.
- Orthotics and prosthetics DME orthotic; Diabetic Shoe(s)/Insert(s); (3) pair

### Foot Exam: *(must be specific and must match 1 of the 6 conditions on step 5 of 9)*

- Diabetic foot exam: normal DP and PT pulses, no trophic changes or ulcerative lesions, and normal sensory exam.
- **Bunion** of the RT foot.

### Orders Placed: *(must align to the actual RX and be attested to)*

- Orthotics and prosthetics DME orthotic; Diabetic Shoe(s)/Insert(s); (3) pair
- I **(Doctor Name)** MD/Do attest that 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.

### Visit Diagnoses: *(must include appropriate qualifying diabetic ICD 10 and specifics to foot exam issues).*

- Primary: Type 2 Diabetes Mellitus with stage 1 chronic kidney disease, without long-term current use of insulin(H) E11.22 - N18.1
- Bunion, Right M21.611

Encounter performed and documented by **(Doctor Name)**, MD/DO - 1/1/2024

Encounter reviewed & Signed by **(Doctor Name)**, MD/DO - 1/1/2024 at 1:15 p.m.