

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

154 Cobblestone Lane | Burnsville | MN | 55337 www.DAHLMEDICALSUPPLY.com

Certifited provider of: Anodyne, Apex, Orthofeet, New Balance & Propet

Dear Doctor:			
A patient of yours: First:	Last:	DOB:	
Contacted us on/_	/ and is inte	erested in getting diabetic shoes in 2023 from	us:
	Dahl Medio	cal Supply	

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. Please fax **FOOT EXAM & CLINICAL NOTES** that are **<u>SIGNED</u> 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 that this process is complicated and takes up a lot of your time and energy. If you have any questions about these forms please contact us at (612) 334-3159.

Please fax all paperwork back to Dahl Medical Supply at (763) 208-6072

Thank you, Dahl Medical Supply Staff



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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: (E (STEP 2 of 9): Check Prescribed Pro		etic Mellitus and
One pair of extra depth shoes	(A5500) with three pairs of cu OR	ustom-molded multi-density inserts (A5513)
One pair of extra depth shoes	(A5500) with three pairs of h	eat-molded multi-density inserts (A5512)
Two pairs of extra depth (A550 **Primary Medical Assistance Patien		n-molded multi-density inserts (A5513)
Two pairs of extra depth (A550 **Primary Medical Assistance Patien		olded multi-density inserts (A5512)
(STEP 3 of 9)Therapeutic Objective	es - MUST CHECK 1:	
Prevent Ulceration and	other pedal complicati	ons
Distribution weight, bala	ance, and plantar press	sure
*DPM, MD, DO, PA, NP or CNS <u>are eligible</u> t	o sign this form per insuranc	e guidelines for Therapeutic Shoes *
Physician Name	Physician Signature	Date
r nysiolan name	i nysiolan signature	Date

Physician Address

Physician NPI #

Duration of usage

12 Months

Physician Fax #

Physician Phone #



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**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**

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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--190 Code:______ (ICD-10 Diagnosis Code Required E08.00 - 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)

(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*):_____ 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:



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Information Needed: 3 of 3 PAGES

(STEP 8 of 9):

Detailed <u>SIGNED</u> Clinical Notes Regarding the indicated foot conditions on RX PAGE 1 (Step 5).

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

EXAMPLE OF WORDING TO SUPPORT THE NEED FOR DIABETIC SHOES

I've written an order for diabetic shoes and inserts. This patient needs diabetic shoes and custom and or heat moldable inserts for the protection of at-risk feet. These prescribed shoes and inserts are medically necessary to maintain current ligament integrity preventing further laxity, protect and support neuropathic feet, and provide an environment for healing



WITHOUT ALL INFORMATION BEING FILLED OUT AND FAXED BACK, MEDICARE & PRIVATE INSURANCE WILL DENY COVERAGE OF SHOES AND THE <u>PATIENT WILL BE RESPONSIBLE FOR COST OF SHOE & INSERTS.</u>

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.

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.

-Dahl Medical Supply