DAHL Medical Supply
Since 1912
Rentals - Service - Sales

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 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

DAHL Medical Supply
Since 1912
Rentals - Service - Sales

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

154 Cobblestone Lane | Burnsville | MN | 55337

www.DAHLMEDICALSUPPLY.com

Comprehensive Diabetic Foot Exam & Shoe Order Form /Intake Form

Complete form for ordering shoes and inserts using Dahl Medical Supply | www.dahlmedicalsupply.com

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:_____Sate:_____ 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:_____Sate:_____ Zip _____

Phone:_____ Fax:_____

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:_____

Measauring 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:**_____

DAHL Medical Supply
Since 1912
Rentals - Service - Sales

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

154 Cobblestone Lane | Burnsville | MN | 55337

www.DAHLMEDICALSUPPLY.com

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	Date
Physician Address	Physician NPI #	12 Months Duration of usage
Physician Fax #	Physician Phone	

DAHL Medical Supply
Since 1912
Rentals - Service - Sales

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

154 Cobblestone Lane | Burnsville | MN | 55337

www.DAHLMEDICALSUPPLY.com

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*)**:_____ 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-meltable 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

Phone Number:_____ Fax Number: _____

DAHL Medical Supply
Since 1912
Rentals - Service - Sales

Phone: (612) 334-3159 | Fax: (612) 746-1058
154 Cobblestone Lane | Burnsville | MN | 55337
www.DAHLMEDICALSUPPLY.com

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).

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.

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

Supplier In-Person Foot Screen Evaluation Prior to Shoe Selection

Patient Name:_____ D.O.B_____

Estimated Duration of Diabetes:_____ Date Last Seen by MD/DO:_____

Fill in the following blanks with a "Y" or "N" to indicate findings on the right or left foot.	Right	Left
Is there a history of a foot ulcer?	_____	_____
Is there a foot ulcer now?	_____	_____
Is there a claw-toe deformity?	_____	_____
Is there swelling or an abnormal shape in the foot?	_____	_____
Is there elevated skin temperature?	_____	_____
Is there limited ankle dorsiflexion?	_____	_____
Are the toenails thick or ingrown?	_____	_____
Is there a heavy callus build-up?	_____	_____
Is there foot or ankle muscle weakness?	_____	_____
Is there an absent pedal pulse?	_____	_____
Can the patient see the bottom of their feet?	_____	_____
Are the shoes appropriate in style and fit?	_____	_____

Do you exam your feet daily? Yes No

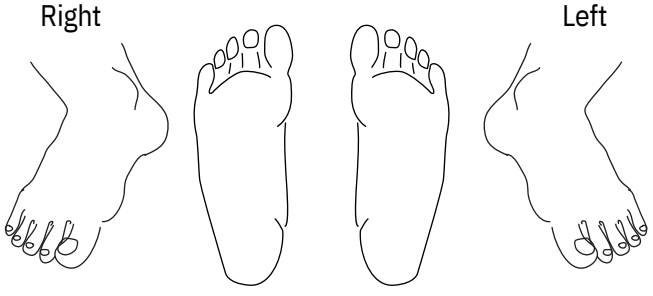
Have you fallen in the past 6 months? When?_____ How?_____

Do you experience any pain at rest in your lower leg(s) or feet? Yes No

Do you experience foot or toe pain that disturbs your sleep? Yes No

Have you suffered a severe injury to the leg(s) or feet? Yes No

Are your toes or feet pale, discolored, or bluish? Yes No



Note corns, calluses or deformities using symbol key below:

Corn/Callus (C) Wound (W) Bunion (B) Redness (R)
Swelling (S) Hammer/Claw toe (HC) Amputation (A)

Foot Complaitns:

_____

_____

_____

_____

_____

Duration of visit:_____MIN

Patient Name:_____ **Fitter Name:_____**

Patient Signature:_____ **Fitter Signature:_____**

Documentation Of In-Person Dispensing

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

154 Cobblestone Lane | Burnsville | MN | 55337

Patient Name:_____ D.O.B_____

Location of In-Person Meeting:_____ Fitter/Dispenser Initials:_____

Shoe Manufacture:_____ Style:_____

Shoe Size:_____ Width:_____ Color:_____

Inserts Provided: Heat-Molded | Custom | Other:_____

Qty: 1 | 2 | 3

- ☐ Statement of Certifying Physician (CMN) Received
  - Visited PCP within 6 months and signed/dated within 3 months.
  - PCP has separate documentation of qualifying conditions diagnosis
- ☐ Prescription Received
  - Signed/dated within 6 months of dispensing date
- ☐ Shoe Care & Use Instructions Provided
- ☐ DMEPOS 30 Supplier Standard Provided
- ☐ Delivery Receipt & Authorized for Payment Signed
  - List item, brand, style, size, etc. of items dispensed

Patients Comments Regarding Needs/Fit:

_____

_____

Fitters Comments Regarding Fit/Accommodations Made During Dispensing:

_____

_____

Follow-Up Instructions:

_____

Patient Name:_____ **Fitter Name:_____**

Patient Signature:_____ **Fitter Signature:_____**