

THE SHOE LAB, INC
INSTRUCTIONS
Fax (813) 641-0319

The Shoe Lab, Inc is trying to help your patients with Diabetic Therapeutic Shoes and Inserts, so we can bill the patients insurance accordingly. Attached you will find:

Statement of Certifying Physician:
(To be signed by the Doctor that is managing the patient's systematic Diabetes)

Physician Order Form/ Prescription:
(To be signed by the Doctor that is managing the patient's systematic Diabetes or Foot Doctor)

Sample of Prescription:
(To be signed by the Doctor that is managing the patient's systematic Diabetes or Foot Doctor)

Doctor's Notes/Diabetic Foot Exam: PLEASE DO NOT FORGET TO FILL OUT NOTES AND SIGN OR SEND US YOUR OWN NOTES!!!! NEW MEDICARE REGULATION REQUIRES SUCH NOTES. WE CAN NOT HELP YOUR PATIENT WITHOUT DOCTORS NOTES! (last page)

To ensure patient qualification for the Diabetic Therapeutic Shoes, Medicare/Insurances requires supplier to have on patient's file prior to delivery of service **Doctor's Notes** from the **certifying physicians**. For your convenience, we are attaching the Diabetes Foot Exam Form. Please fill out the attached form or you can send us your own notes.

Doctors notes have to describe one of the qualifying conditions: the specific foot deformity (bunion, hammer toe, etc), the location of a foot's ulcer, callus or a history of one of these conditions. Also, the type of foot amputation or symptoms, signs or test supporting a diagnosis of peripheral neuropathy, plus the presence of a callus or the specifics about poor circulation in the feet.

For your convenience, we are attaching the Diabetes Foot Exam Form. Please keep in mind that the doctor's notes should be signed and dated **the same date or prior** to the Statement of Certifying Physician.

Please sign and fax back to: **(813) 641-0319**

Thanks in advance for your support.

Regards,

Facsimile

CONFIDENTIAL

Fax back to: The Shoe Lab, Inc. (813) 641-0319

TO: Jeffrey Corniello, C Ped

FROM:

FAX NUMBER: 813-641-0319

DATE:

TEL: 813-645-5800

NO. OF PAGES (including Cover Page):

RE: **DIABETIC SHOES - PATIENT:** _____

Attached you will find documents so you can proceed to provide the above patient with services.

Regards,

THE SHOE LAB, INC
 (Please fax back to 813 641-0319)

Statement of Certifying Physician for Diabetic Therapeutic Shoes

To be filled out by the doctor that is *managing the patient's systematic diabetes*, M.D. or D.O.

Patient Name: _____

DOB: _____ ID#: _____ TELEPHONE: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

CERTIFICATION: I certify that the following statements are true:

1. This patient has diabetes mellitus:

Yes

No

IMPORTANT
DON'T FORGET TO MARK

2. This patient has ONE or more of the following conditions. (Mark all that apply)

- _____ a. Previous amputation of the other foot, or part of either foot, or
- _____ b. History of previous foot ulceration of either foot, or
- _____ c. History of pre-ulcerative calluses of either foot, or
- _____ d. Peripheral neuropathy with evidence of callus formation of either foot, or
- _____ e. Foot deformity of either foot, or
- _____ f. Poor circulation in either foot

IMPORTANT
DO NOT FORGET
to mark all that apply
to patient for the
**** DIABETIC SHOES ****

- 3. I'm treating this patient under a comprehensive plan for his/her diabetes.
- 4. This patient needs special shoes (depth or custom-molded shoes) with multiple density therapeutic insoles because of his/her diabetes.
- 5. Patient has diabetes mellitus and the presence of the conditions above marked is documented in the patient's medical record.
- 6. By signing below **Certifying Physician** agrees that he/she has either personally documented that the beneficiary met one or more of criteria 2a to 2f or obtained documentation from another clinician documenting the beneficiary met one or more of criteria 2a to 2f and the certifying physician indicated agreement with the information by initialing and dating the record. Certifying Physician agrees to provide copies of patient's records with the above documentation.

Disclaimer Diagnosis – Diabetes Mellitus Certification:	If Diagnosis is left blank, diagnosis specified on the "Physician Order Form/Prescription" is the Diagnosis that will prevail for patient's prescription. If doctor marks or writes that patient does has diabetes mellitus on "Statement of Certifying Physician," and if the diagnosis is not specified on the "Statement of Certifying Physician", "Physician Order Form" and/or "Prescription" the diagnosis that will prevail for patient's prescription is 250.00. If the doctor does not mark that patient has diabetes mellitus but specify the diagnosis code as a diabetic related code (for example 250.00) then The Shoe Lab, Inc. will imply that the patient does have diabetes mellitus. By the doctor signing this "Statement of Certifying Physician", the doctor understands and/or agrees to this disclaimer.
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Please specify Diagnosis:	ICD 9 Codes	→	250.00	→	250.93	→	250.63	→	Other	
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PHYSICIAN SIGNATURE _____ DATE: _____

Physician Name: _____ Phone # _____

UPIN: _____ NPI: _____ PECOS: Yes: _____ No: _____

Address _____ City _____ State _____ Zip _____

THE SHOE LAB, INC

PHYSICIAN ORDER FORM/PRESCRIPTION

Patient Name: _____ Telephone (incl. area code): _____

The **Physician Order Form** is requested to corroborate medical necessity for products and/or services provided by The Shoe Lab, Inc.

Please mark all that applies to patient. **Please select below as prescribed: L=Left, R=Right, LR=Bilateral/1Pair**

Note to Physician: The instructions below are recommendations. If Physician wants to change the instructions for the Quantity, Frequency and Duration of Need, Physician may do so under "Other Specifications." If Physician agrees with our recommendations, such recommendations will prevail as the Physician's instructions/Prescription.

Note to Patient: If there is an injury caused by the product(s) provided by The Shoe Lab, Inc., patient must contact us and discontinue the use of such product(s) immediately. Patient must also seek physician's advice. For how to use device(s), patient must follow instructions provided at time of service.

DIABETIC THERAPEUTIC SHOES

Quantity: L= One Left Shoe Prescribed. R = One Right Shoe Prescribed. LR = One Pair of Shoes Prescribed (Bilateral). If L, R, LR and/or quantity is not selected, one pair of shoes will be the quantity prescribed. If off-the-shelf or custom shoes are not selected, one pair of off-the-shelf or custom shoes will be the item prescribed. Patient will receive custom shoes if feet can not be accommodated on off-the-shelf shoes. If custom shoes are prescribed but patient can be accommodated on an off-the-shelf diabetic shoes, off-the-shelf diabetic shoes will be the item prescribed.

Frequency: In order to provide maximum protection to the diabetic foot, we recommend wearing the Diabetic Therapeutic Shoes at all times while walking, as long as shoe(s) fit well, is/are in proper condition and/or until the patient is re-evaluated by physician. We recommend wearing the diabetic shoes for the first three days at home on the carpet to ensure the shoes were correctly fitted. If no red marks, discomfort and/or ulcerations are present, then patient can start wearing the shoe(s) at all times.

Duration of Need: One year from the date of service and/or until patient is re-evaluated by physician.

	A5500	Off the Shelf Depth - Inlay Diabetic Therapeutic Shoes	L	R	LR	
	A5501	CUSTOM - Diabetic Therapeutic Shoes	L	R	LR	

INSERTS: Quantity: Recommended = 6 inserts = 3 pairs. L= Left Insert Prescribed. R = Right Insert Prescribed. LR = Bilateral Inserts Prescribed. In order to provide maximum protection to the diabetic foot, Diabetic Therapeutic Shoes should be dispensed with diabetic inserts. If L, R, LR and/or quantity is not selected, six pre-fabricated or custom inserts will be the amount prescribed (bilateral). If off-the-shelf or custom inserts are not selected, one pair of off-the-shelf or custom inserts will be the item prescribed. Patient will receive custom inserts if feet can not be accommodated with an off-the-shelf insert. If custom diabetic inserts are prescribed but patient can be accommodated on an off-the-shelf diabetic insert, off-the-shelf diabetic inserts will be the item prescribed.

Frequency: Doctor recommends each insert be replaced at least every 4 months or sooner (if inserts have worn out.) Or, alternate (rotate) insert(s) provided inserting them in the shoe(s) received and or into patient's additional extra depth shoe(s) as long as shoes are in good condition. Inserts must be worn inside Diabetic Therapeutic Shoes to protect patient's foot. Inserts do wear out; consequently, it is important to replace/alternate insert(s) as instructed. The Shoe Lab, Inc. is not responsible for any ulcerations, injuries and/or amputations that may occur if the patient decides not to wear insert(s) inside the diabetic shoes. If inserts have worn out do not keep using them.

Duration of Need: One year from the date of service and/or until patient is re-evaluated by physician.

						Other Amount
	A5512	Pre-fabricated Diabetic Therapeutic Insert	L	R	LR	
	A5513	Custom Diabetic Therapeutic Insert	L	R	LR	
	L5000	Partial foot, Toe Filler, Shoe insert	L	R	LR	
	L3000	Custom Molded Orthotic/Orthoses	L	R	LR	

MODIFICATIONS

	A5503	Roller or Rigid Rocker	L	R	LR	DX: (Other Specifications): _____ _____
	A5504	Wedge(s)	L	R	LR	
	A5505	Metatarsal Bar	L	R	LR	
	A5506	Off-set heel	L	R	LR	
	A5507	Flared Heel, Elevation and Others:	L	R	LR	

GAUNTLET (Thermal Ankle/Foot Stabilizer/Thermal Foot Gauntlet/AFG Stabilizer/Gauntlet)

Quantity: L= One Left Gauntlet Prescribed. R = One Right Gauntlet Prescribed. LR = One Pair of Gauntlet Prescribed (Bilateral). If L, R, LR and/or quantity is not selected, one pair of Gauntlet will be the quantity prescribed.

Frequency: We recommend wearing the Gauntlet every night while sleeping. Gauntlet must not be worn as a shoe because heel is exposed. The Shoe Lab, Inc. and/or Prescribing Physician does not assume responsibility if patient injures his/her foot/heel while wearing gauntlet.

Duration of Need: One year from the date of service and/or until patient is re-evaluated by physician.

	L1902	Thermal Foot Gauntlet/AFO, Ankle Gauntlet/AFG Stabilizer	L	R	LR	2	2
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Please specify Diagnosis:	ICD 9 Codes	→	250.00	→	250.93	→	250.63	→	Other
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PHYSICIAN SIGNATURE _____ DATE: _____

Physician Name: _____ Phone # _____

UPIN: _____ NPI: _____ PECOS: Yes: _____ No: _____

Address _____ City _____ State _____ Zip _____

THE SHOE LAB, INC

Prescription

Mark and Sign Below what applies to Patient:

(Please fax back to 813 641-0319)

Patient Name: _____

DOB: _____ HIC#: _____ TELEPHONE: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

	1 Pair of Off-The-Shelf Diabetic Therapeutic Shoes Off-The-Shelf Diabetic Inserts (6 units) {3 pairs, one year supply}
	1 Pair of Off-The-Shelf Diabetic Therapeutic Shoes Off-The-Shelf Diabetic Inserts (6 units) {3 pairs, one year supply} Thermal Foot Gauntlet (Bilateral, 1 pair)
	1 Pair of Custom Diabetic Therapeutic Shoes Custom Diabetic Inserts (6 units) {3 pairs, one year supply}
	1 Pair of Custom Diabetic Therapeutic Shoes Custom Diabetic Inserts (6 units) {3 pairs, one year supply} Thermal Foot Gauntlet (2 units, Bilateral, 1 pair)
	1 Pair of Off-The-Shelf Diabetic Therapeutic Shoes Custom Diabetic Inserts (6 units) {3 pairs, one year supply}
	1 Pair of Off-The-Shelf Diabetic Therapeutic Shoes Custom Diabetic Inserts (6 units) {3 pairs, one year supply} Thermal Foot Gauntlet (2 units, Bilateral, 1 pair)
	1 Pair of Off-The-Shelf Diabetic Therapeutic Shoes Off-The-Shelf Diabetic Inserts (____Units) {____Inserts, one year supply} Left:____Right:____Bilateral:____ Toe Filler {indicate left, right or bilateral}{____Units, one year supply} Left:____Right:____Bilateral:____ Thermal Foot Gauntlet (2 units, Bilateral, 1 pair)
	1 Pair of Custom Diabetic Therapeutic Shoes Custom Diabetic Inserts ____Units) {____Inserts, one year supply} Left:____Right:____Bilateral:____ Toe Filler {indicate left, right or bilateral}{____Units, one year supply} Left:____Right:____Bilateral:____ Thermal Foot Gauntlet (2 units, Bilateral, 1 pair)
	1 Pair of Off-The-Shelf Diabetic Therapeutic Shoes Toe Filler {indicate left, right or bilateral}{____Units, one year supply} Left:____Right:____Bilateral:____ Thermal Foot Gauntlet (2 units, Bilateral, 1 pair)
	1 Pair of Custom Diabetic Therapeutic Shoes Toe Filler {indicate left, right or bilateral}{____Units, one year supply} Left:____Right:____Bilateral:____ Thermal Foot Gauntlet (2 units, Bilateral, 1 pair)
	Other:

Disclaimer Diagnosis -Diabetes Mellitus Certification:	If Diagnosis is left blank, diagnosis specified on the "Statement of Certifying Physician" and/or Physician Order Form/Prescription" is the Diagnosis that will prevail for patient's prescription. If doctor marks or writes that patient does has diabetes mellitus on "Statement of Certifying Physician," and if the diagnosis is not specified on the "Statement of Certifying Physician", "Physician Order Form" and/or "Prescription" the diagnosis that will prevail for patient's prescription is 250.00. If the doctor does not mark that patient has diabetes mellitus but specify the diagnosis code as a diabetic related code (for example 250.00) then The Shoe Lab, Inc. will imply that the patient does has diabetes mellitus. By the doctor signing this "Physician Order Form", the doctor understands and/or agrees to this disclaimer.
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Please specify Diagnosis:
ICD 9 Codes
→
250.00
→
250.93
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250.63
→
Other

PHYSICIAN SIGNATURE: _____ DATE: _____

Physician Name: _____ Phone # _____

UPIN # _____ NPI _____ PECOS: Yes: _____ No: _____

Address _____ City _____ State _____ Zip _____

FOOT EXAM – PLAN OF TREATMENT

Patient Name: _____

DOB: _____ HIC#: _____ TELEPHONE: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Check the Appropriate Boxes to Indicate Findings	Left	Right
History of Previous Amputation		
History of Foot Ulcer(s)		
Current Foot Ulcers(s)		
History of Pre-ulcerative Callus		
Callus Buildup		
Toe Deformity (Hammertoe, bunion, etc.) Circle Digit #	1 2 3 4 5	1 2 3 4 5
Abnormal Foot Shape		
Lower Extremity Pain		
Blister/Laceration		
Peripheral Neuropathy With Evidence of Callus Formation		
Elevated Temperature		
Can Patient See Plantar Foot		
Edema		

VASCULAR FINDINGS

- Dorsalis Pedis Pulse
- Post Tibial Pulse
- Foot Hair Growth
- Capillary Refill
- Cold Feet
- Claudications
- Pallor
- Poor Circulation

SYMPTOMATIC


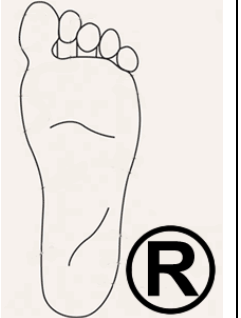
Additional Notes:


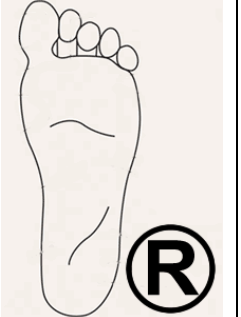
*The **above notations** constitute this patient doctor's notes and foot examination. These notes are part of a comprehensive plan for the treatment of this patient's foot.*


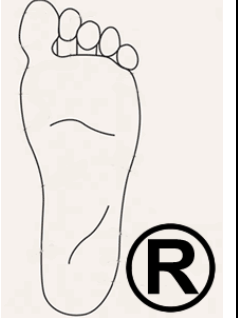
Physician's Signature: _____

Physician's Name: _____

Date: _____

PLANTAR VIEW	
	
Mark Callus/History Location(s)	

	
Mark Ulcer/History Location(s)	

	
Foot Sensation/Skin Condition Diagram	
MARK SYMBOLS ABOVE ON DIAGRAM	
1. Foot Sensation: Patient Can feel 5.07 (10gram) nylon filament [+] Cannot feel 5.07 (10gram) nylon filament [-] 2. Skin Condition: R=Redness; S=Swelling; W= Warmth D=Dryness; M=Maceration	