Adaptive Prosthetics

'Together We Can Adapt to Challenges in Life'

Glastonbury
52 National Drive
Glastonbury, CT 06033
Phone 860-633-7298

www.AdaptiveCT.com
Fax: 860-659-1282

Norwich
426 Salem Turnpike
Bozrah, CT 06334
Phone: 860-237-5522

◆ Artificial Limbs ◆ Custom Orthopedic Bracing ◆ Artificial Limbs ◆ Custom Orthopedic Bracing ◆

Dear Physician,

In order for diabetic shoes and inserts to be covered by Medicare for your patient, the following information must be completed by you and received in our office.

1. Detailed Prescription **(MD/DO/DPM)**

2. The Statement of Certifying Physician for Therapeutic Footwear (SCP) which must be completed within the last 3 months. **The physician, (MD/DO ONLY) must certify that the patient has diabetes mellitus and one or more of the qualifying conditions listed on the form.**

   Medical records from the physician treating the patient for his/her diabetic condition from an in-person visit within the last 6 months.

   The physician's medical records must include the following (in addition to the SCP)

   - Must state that the patient was seen "in person"
   - Must state that the patient has diabetes mellitus
   - Must state and describe the patient's qualifying conditions as in the Diabetic Verification Form
   - Must state there is a "need for diabetic shoes and inserts"
   - Must state that you are "treating the patient for their comprehensive plan of care for diabetes"
   - Must be dated within the last 6 months
   - Must state the patient's prognosis with diabetic shoes **(MD/DO ONLY)**

Thank you for taking the time to provide us with proper documentation to service your patient. If at all possible, it would be preferred to give this information to the patient at the time of the office visit. If you have any questions or concerns, please do not hesitate to contact us.

Thank you,
Adaptive Prosthetics

Prescription for Therapeutic Footwear
(DPM, NP, PA, MD, DO)

Patient Name:____________________________**DOB:**______________

Diabetes Mellitus: ICD-10______________ (Please provide ICD code)
DM Type II w/Neuropathy **E11.** __ __ __ (add 4th - 6th numeral)
DM Type I w/Neuropathy **E10.** __ __ __ (add 4th – 6th numeral)

Dx: Comorbidity Required

___ Acquired Deformity of Foot ______ of Ankle ______ **(M21.969)**
___ Congenital Foot Deformity ______ **(Q66.0 – Q66.9)**
___ Other Deformities of Feet___**(M21.6X1= Right)**___**(M21.6X2=Left)**
___ Plantar Fasciitis **(M72.2)** _____ Plantar Fibromatosis______ **(M72.2)**
___ Bunion(s) ___ **(M20.11)-Right**___ **(M20.12)-Left**
Hammertoe(s) ___ **(M20.41) - Right** ___ **(M20.42) Left**
___ Callus(es) **(L84)** ____ Corn(s) **(L84)**
___ Peripheral Vascular Disease ___ Specified **(I73.89)** ___ Unspec. **(I73.9)**
___ Charcot Arthropathy ____ **M14.671-Rt** ____ **M14.672-Lt**
___ Hx Previous foot **ulcer (Z86.31)** ☐ DM Foot Ulcer(s) **(E08.621**
___ Amputation(s) ______________**(S88.xxx, Z89.xxx Etc. Provide ICD-10 code)**
___ Other DX (describe)____

Length of Need:______________________

RX: Diabetic Footwear

___1 Pair Diabetic Depth Shoes **(A5500)** w3 pr heat moldable inserts **(A5512)**
___1 Pair Diabetic Depth Shoes **(A5500)** w3 pr custom molded inserts **(A5513/A5514)**
___1 Pr Diab Custom Depth Shoes **(A5501)** w 2 pr custom molded inserts **(A5513/A5514)**
___ Partial Foot Prosthesis/Toe Filler **(L5000)** ___Right: ___Left
___ Other ____

Comments:____

Name:_________________________________NPI #____________________

Address:____

Signature:__________________________________Date:________________

A Copy of the Doctor's PROGRESS NOTE is required.
Please Fax To: Adaptive Prosthetics - (860) 659-1282

Take this to the Doctor who orders your diabetic medications

Statement Certifying Diabetic Verification Form(MD or DO Only)

Patient Name:__________________________________**DOB:**____________

I certify that all of the following statements are true:

1) This patient has diabetes mellitus. ICD-10 Code___________
(Please provide ICD-10 code E08-E13)

2) This patient has one or more of the following conditions:

One listed condition MUST be included in the Doctor's PROGRESS NOTE:

Check all that apply

___ History of partial 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

3) Within the **past 6 months**, an exam has been performed and qualifying condition(s) have been documented.

4) I am treating this patient under a comprehensive plan and care for his/her diabetes; and

5) This patient needs special shoes (depth or custom molded) and/or inserts because of his/her diabetic condition.

6) With diabetic footwear, the patients' prognosis is _______________

Certifying Physician Information:

MD or DO Must Sign
Co-Signing Not Allowed

Name:________________________________NPI #_________________

Address:____

Signature:________________________________Date:_____________

A Copy of the MD or DO's Progress Note is required.
Please Fax To: Adaptive Prosthetics – (860) 659-1282