LoDanos FOOTWEAR

Updated: January 2014

Dear Medicare/Diabetic Customer,

Attached are the forms your physician will need to fill out your Medicare claim in 2014.

1) Take the two forms to the physician that treats your diabetes. Make sure that your name and phone number are on the forms.
2) Ask your physician to fill out and sign the forms per the instructions.
3) Make sure your physician examines your feet and notes the examination in your medical records.
4) Bring the original two forms to either of our locations (Alliance or Canton, OH) for your initial fitting. Your physician's office can also fax them to our store.
5) Please come in within 3 months of the physician's signature.

We know you have carefully considered the advantages of coming to LoDano's Footwear for your diabetic shoes. Fitting shoes, carrying the correct styles, having the inventory on hand and providing you with a knowledgeable diabetic/medicare team is exactly what you get at our store. We know that there are other, often less desirable, places to get this service. Please consider the many benefits of coming to LoDano's Footwear before you agree to get shoes and supports from an office or lab that doesn't inventory footwear or have professional people that know footwear.

Our diabetic/medicare customers are our most loyal customers and we thank you sincerely.

## Our Diabetic Assistance Team Hours:

Alliance Location: Monday and Tuesday 10A.M. - 5P.M.
Canton Location: Wednesday and Thursday 10A.M. - 4P.M.

DO NOT FAX THIS SHEET

**Mary Jo** - Diabetic Coordinator

**Jenny** - Certified/Licensed Pedorthist

We are happy to help you with your diabetic footwear needs.

Sincerely,
LoDano's Footwear Diabetic Assistance Team

Physician's office can fax the completed form #1 and form #2 or the patient can return the original forms to LoDano's Footwear.

Canton Fax: (330) 493-5755 Alliance Fax: (330) 821-3378

**Alliance Location: 1824 W. State St. 44601 • phone: (330) 821-0944 • fax: (330) 821-3378**
**Canton Location: 4691 Dressler Rd. N.W. 44718 • phone: (330) 493-0944 • fax: (330) 493-5755**

**These forms are available at www.lodanosfootwear.com • Go to the Medicare tab, download the forms.**

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# Physician Instruction Sheet

Dear Physician and/or Staff,

We are requesting your assistance in providing the above patient with diabetic footwear, as provided under the Therapeutic Shoes for Persons with Diabetes Act (TSPD). In order to qualify for Medicare reimbursement, the following forms must be reviewed and completed:

DO NOT FAX THIS SHEET

1) PRESCRIPTION FOR DIABETIC SHOES AND INSERTS
COMPLETE, SIGN AND DATE

2) STATEMENT OF CERTIFYING PHYSICIAN
COMPLETE, SIGN AND DATE
PLEASE CHECK APPROPRIATE ITEMS, BASED ON YOUR DIAGNOSIS

3) MEDICARE REQUIRES THAT YOUR PATIENT NOTES INDICATE THAT HE/SHE HAS ONE OF THE SIX QUALIFYING CONDITIONS LISTED ON THE STATEMENT OF CERTIFYING PHYSICIAN.

*If LoDano's Footwear receives an audit from Medicare on one of your patients, it is required we have a copy of your patient notes reflecting a need for diabetic shoes and insoles. This is a Medicare requirement.

Please fax forms back to Canton (330) 493-5755 or Alliance (330) 821-3378
We greatly appreciate your assistance in serving the needs of this patient.

Mary Jo Schafer
Diabetic Coordinator

Jennifer Giordano
Certified/Licensed Pedorthist

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**FORM #1**

**1** Rx Physician Signature Required

## PRESCRIPTION FOR THERAPEUTIC SHOES AND INSOLES

Patient Name: _____ DOB: _____

Patient Phone Number: _____

1. Extra-depth therapeutic shoes: 1 pair, to be worn for a duration of 12 months,

2a. Multi-density, custom fabricated insoles: 3 pair, each to be worn for a 4 month period over one year.

or 2b. Prefabricated diabetic insoles: ___ pair, each to be worn for a ___ month period over one year.

3. Other: _____

**Physician's Signature:** _____ **Date:** _____

**2** Statement Physician Signature Required

## STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

I certify that all of the following statements are true:

Physician must check all items that apply and sign below:

1. This patient has diabetes mellitus: □ Type 1 □ Type 2
   Check ICD-9 code that applies: □ 250.00 □ 250.01 □ 250.02 □ 250.03
2. This patient has one or more of the following conditions.
   Physician must check all that apply and sign below.
   - □ 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. I am treating this patient under a comprehensive plan of care for his/her diabetes
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes

**Physician's Signature:** _____ **Date:** _____

**3** Physicians Information Please Complete

Physician's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Physician's NPI #: _____

Physician's office can fax the completed form #1 and form #2 or the patient can return the original forms to LoDano's Footwear.

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FORM #2

# Diabetic Foot Evaluation and Assessment
# Patient Progress notes

Patient Name: _____ HIC#: _____

Patient Phone Number: (  ) _____

## Vascular

| | | | | |
|---|---|---|---|---|
| Pedal Pulses: | Normal | Weak | B/L | R L |
| Absent Posterial Tibial | B/L | R L | | |
| Absent Dorsalis Pedis | B/L | R L | | |
| Edema: | Mild | Moderate | B/L | R L |
| Temperature: | Normal | Elevated | B/L | R L |

Other: _____

## Neurological

Peripheral Neuropathy: Mild Moderate Severe B/L R L

Other: _____

## Dermatological

Callus: B/L R L Ulcers: B/L R L

Other: _____

## Digital Deformities

Hammer Toes B/L R L

Claw Toes: B/L R L

Bunions: B/L R L

Ingrown Tow Nail: B/L R L

Muscle Strength: Normal Weak B/L R L

Other: _____

___ Previous Amputation: B/L R L

___ History of Previous Foot Ulceration: B/L R L

___ History of Pre-Ulcerative Callus: B/L R L

___ Peripheral Neuropathy w/ evidence of callus formation B/L R L

___ Foot Deformity: B/L R L

___ Poor Circulation: B/L R L

**1 pair of extra depth therapeutic shoes and 3 pairs of multi-density custom fabricated supports.**

**Physician's Signature:** _____ **Date:** _____

Physician's office can fax the completed form #1 and form #2 or the patient can return the original forms to LoDano's Footwear.

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