LoDano's FOOTWEAR

Updated: March 2016

Dear Medicare/Diabetic Customer,

Attached are the forms your physician will need to fill out for your Medicare claim in 2016.

1. Take the two forms to the physician that treats your diabeties. Make sure that your name and phone number is on the forms.
2. Ask your physician fill to out and sign the forms per the instructions.
3. Make sure your physician examines your feet and notes the examination in your medical record.
4. Bring the original three 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. Your prescription is only valid for 3 months, so, please com in within 3 months of the date of 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 LoDano's;s Footwear before you agree to get shoes and supports from an office or a lab that doesn't inventory footwear or have professional people who 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 - 10am - 5pm

Canton Location - Wednesday and Thursday - 10am - 4pm

Mary Jo - Diabetic Coordinator & **Jenny** - Licensed/Certified Pedorthist are happy to help you with your footwear fitting.

Sincerely,
LoDano's Footwear Diabetic Assistance Team

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

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

Alliance Location • 1824 W. State Street • 330-821-0944 • 1-888-805-4425 • fax: 330-821-3378
Canton Location • 4691 Dressler Road NW • 330-493-0944 • 1-800-705-4425 • fax: 330-493-5755
www.LoDanosFootwear.com • Contact@LoDanosFootwear.com
These forms are available at www.lodanosfootwear.com Go to the Medicare tab, download the forms.

LoDanos FOOTWEAR

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

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.

Revised: January 2014

LoDanos FOOTWEAR

Revised: March 2016

Prescription for Therapeutic Shoes & Insoles

1
Rx Physician Signature Required

Patient Name:_____ DOB: _____

Patient Phone Number: ( )_____

1. Extra-depth therapeutic shoes: l 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.
2b. Prefabricated diabetic insoles: _ pair, each to be worn for a_ month period over one year.
3. Other:_____

Physician's Signature: _____ Date/Start Date: _____

Statement of Certifying Physician for Therapeutic Shoes

2
Statement Physician Signature Required

I certify that all of the following statements are true:

1. This patient has diabetes mellitus: **ICD 10 Code**: _____
   □Type 1 □ Type 2 □ Controlled □ Uncontrolled
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 extra depth therapeutic shoes and insoles because of his/her diabetes
5. **Per Medicare Policy:** Attach a signed copy of progress/ chart notes, lab reports, ect. that confirm you have had a face-to-face encounter with the patient, in the past 6 months, pertaining to diabetic shoes and the diagnosis marked above.

Physician's Signature: _____ Date/Start Date: _____

MUST BE SIGNED BY M.D. OR D.O.

3
Physician Information Please Complete

Physician's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Physician's NPI #: _____

Alliance Location • 1824 W. State Street • 330-821-0944 • 1-888-805-4425 • fax: 330-821-3378
Canton Location • 4691 Dressler Road NW • 330-493-0944 • 1-800-705-4425 • fax: 330-493-5755
www.LoDanosFootwear.com • Contact@LoDanosFootwear.com

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

LoDanos FOOTWEAR

Revised: March 2016

Diabetic Foot Evaluation and Assessment
Patient Progress notes

Patient Name: _____ HIC#: _____

Patient Phone Number: ( ) _____ DOB: _____

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	Severe	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: _____

Alliance Location • 1824 W. State Street • 330-821-0944 • 1-888-805-4425 • fax: 330-821-3378
Canton Location • 4691 Dressler Road NW • 330-493-0944 • 1-800-705-4425 • fax: 330-493-5755
www.LoDanosFootwear.com • Contact@LoDanosFootwear.com

Revised: January 2013

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