



Patient's Name:

Order Date:

Phone Number:

Date of Birth:

Bilateral Diabetic Shoes & Custom Inserts

Physician Signature:

ICD-10:

Print Physician Name

Physician Phone:

NPI:

1437 Parkview Dr, Suite 200, Twin Falls, ID 83301

Phone: 208-733-0505

Fax: 208-734-0766

1600 Overland Ave, Suite C, Burley, ID 83318

Phone: 208-878-0500

Fax: 208-734-0766



OrthoPro of Twin Falls Inc

1437 Parkview Drive, Suite 200 Twin Falls, ID 83301
 1600 Overland Ave, Suite C Burley, ID 83318
 Tel: (208) 733-0505 Fax: (208) 734-0766

Standard Written Order

Patient Information			
Patient Name (Last, First, MI)		Patient ID	Patient DOB
			Device Type Bilateral Diabetic Shoes & Custom Inserts
Street Address		City, State, Zip/Postal Code	
		Country USA	
L-Code	Qty	Description	
A5500	2	FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF OFF-THE-SHELF DEPTH-INLAY SHOE MANUFACTURED TO ACCOMMODATE MULTI- DENSITY INSERT(S), PER SHOE Justification: Seamless, lined diabetic shoe to prevent sheer and friction, protect skin integrity, and provide enough depth to accommodate a custom diabetic insert.	
A5514	6	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERTS, MADE BY DIRECT CARVING WITH CAM TECHNOLOGY FROM A RECTIFIED CAD MODEL CREATED FROM A DIGITIZED SCAN OF THE PATIENT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER (OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH Justification: FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, MADE BY DIRECT CARVING WITH CAM TECHNOLOGY FROM A RECTIFIED CAD MODEL CREATED FROM A DIGITIZED SCAN OF THE PATIENT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER (OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH to conform to and protect the patient's foot secondary to the effect of diabetes.	
Prescription			
Projected Monthly Frequency Daily		Estimated Length of Need 12 Months	Order Date
Insurance/Medicare ID#		Diagnosis Type 2 diabetes mellitus without complications	ICD E11.9
Physician NPI		Physician's Printed Name	

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

 Physician's Signature
Must be an MD or DO

 Date



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Thank you for choosing OrthoPro for your diabetic footwear needs.

Medicare requires us to have very specific documentation from the doctor you see for diabetes before they will pay for diabetic footwear.

Please have your physician fill in and sign the Standard Written Order.

Please take the enclosed Statement of Certifying Physician to your doctor **(must be an MD or DO)** and ask them to circle the relevant qualifying conditions and sign the document. The document must be signed within 3 months prior to date of delivery.

Also, have your doctor document in the chart notes you have diabetes and need diabetic footwear for your qualifying condition.

For example, if your doctor circles you have foot deformity and poor circulation the chart notes would need to state, "patient is diabetic and needs diabetic footwear due to foot deformity and poor circulation."

The visit with your doctor and the relevant chart notes must be within 6 months prior to the date of delivery of your shoes and inserts.

Medicare will not pay for shoes and inserts if the doctor's chart notes aren't specific enough. Most other insurance companies follow Medicare guidelines; therefore, we require this documentation for all insurance companies.

We will schedule you for evaluation and scans of your feet for your diabetic footwear when you bring the required documentation to our office.

Quick View Checklist

- 👤 Schedule appointment with diabetic doctor (MD or DO)
- 👤 Have physician circle qualifying condition on Enclosed Statement of Certifying Physician
- 👤 Have your **MD or DO physician** sign Statement of Certifying Physician
- 👤 Have your **MD or DO physician** document in your chart notes that you have diabetes, need diabetic footwear and the reason why (same as circled qualifying condition)
- 👤 Have your physician fill in and sign the Standard Written Order
- 👤 Ask physician for copy of chart notes
- 👤 Bring, fax or mail Statement of Certifying Physician, Standard Written Order and chart notes to our office.
- 👤 Schedule an appointment with our office for evaluation and impressions for your diabetic footwear

Statement of Certifying Physician for Therapeutic Shoes

Any condition checked on this form *MUST* be documented in recent diabetic foot exam notes!

Patient Name: _____ DOB: _____

Insurance ID#: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
 - a) History of partial or complete amputation of the foot
 - b) History of previous foot ulceration
 - c) History of pre-ulcerative callus
 - d) Peripheral neuropathy with evidence of callus formation
 - e) Foot deformity
 - f) 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 signature: _____

Date Signed: _____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

Physician address:

Physician NPI: _____