MURDOCH SHOES

623 Bloomfield Ave., Bloomfield, NJ 07003
973-748-6484

Dear Medicare Customer

In order for Medicare to cover Diabetic footwear, they require documentation from the Physician that treats your diabetes. This is either your **Primary Care** or your **Endocrinologist**.

BEFORE YOU COME INTO MURDOCH SHOES:

- Go to the physician treating your diabetes
  - Medicare requires that this 'certifying physician' be an **MD or DO**.
  - The 'certifying physician' cannot be a DPM, PA or APN.
- During your doctor visit, this certifying physician must examine your feet and
  1. Complete and sign the Statement of Certifying Physician – and -
  2. Complete and sign the Prescription for Therapeutic Footwear – and -
  3. Complete and sign office visit clinical notes that documents continual management of your diabetes – and – states you have one or more of the 6 qualifying conditions for diabetic footwear listed on the certification form.
- Before you leave the doctor's office, be sure you have the certification form, the prescription, and a copy of your office visit clinical notes. All must be signed.

It is **YOUR RESPONSIBILITY** to obtain the required documentation prior to coming to Murdoch Shoes. Failure to do so will cause Medicare to deny your claim, thus holding YOU financially liable for payment.

BRING THE FOLLOWING TO MURDOCH SHOES

1. Your completed Statement of Certifying Physician form. Cannot be older than 90 days.
2. A Prescription for Therapeutic Footwear. Cannot be older than 90 days.
3. A **signed** copy of your physician's clinical notes from your doctor's visit – the same doctor that signed your certification form. These notes must make reference that your feet were examined –and- must contain a statement you have the qualifying condition(s) checked off on the certification form.

Do not come in for a fitting unless you have all 3 signed documents in your hands.

FAX TRANSMITTALS

We **no longer accept** fax transmittals of above documentation. We do not have the staff to support the phone inquiries that they generate. Bring all required documentation into our store.

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Statement of Certifying Physician for Therapeutic Footwear

Patient Name:_____ Date of Birth: _____

I certify that the following 4 statements are true:

1. This patient has diabetes mellitus. Diagnosis code: _____
2. This patient has one or more of the following foot conditions:
   (**check all that apply**)

_____ History of partial or complete foot amputation	_____ Foot deformity
_____ History of pre-ulcerative callous	_____ Poor circulation
_____ Peripheral neuropathy with callus formation	_____ Previous ulcer(s)

   NOTE: Any condition checked above needs to be clearly stated in the patient's medical records
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) and inserts because of his/her diabetic condition

Certifying Physician Information

Note: This form, and the supporting clinical notes, must be authored by the **MD or DO** caring for the patient's diabetes. Medicare will not accept it from a DPM, PA or APN.

Name (printed) _____ NPI# _____

Address _____

By signing this form, I agree I have performed an in person evaluation of this patient and that the clinical notes documented during that visit meet the clinical note guidelines below.

Signature _____ Date: _____

Clinical Note Guidelines (must be met for Medicare to cover diabetic footwear)

a. Must explicitly state that your patient has diabetes and assign a 5 digit ICD code
b. Must explicitly demonstrate evidence you are treating the patient under a comprehensive plan of care for diabetes. Elaborate on portions of the plan: test results, exams, medicine, nutrition, etc
c. Must explicitly state "The patient would benefit from diabetic footwear to protect their feet"
d. Must explicitly document a foot exam, **and** most importantly, document evidence that the foot condition(s) checked above under #2 exist.
e. Must be signed by the certifying physician (MD or DO).

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Prescription for Therapeutic Footwear and Inserts

Patient Name:_____ Date of Birth:_____

Dispense (**check one**)

____ 1 pair of extra-depth **shoes** and 3 pair of heat molded multi-density **inserts**

____ 1 pair of extra-depth **shoes** and 3 pair of custom molded multi-density **inserts**

____ 1 pair of custom molded **shoes** and 3 pair of custom molded multi-density **inserts**

Medicare recommends patients with diabetes receive 3 pair of inserts to be rotated every 4 months

Additional modifications requested:

____ Custom Toe Filler **Circle one**: Left Right B/L

____ Elevation _____

____ Other _____

Diagnosis: _____

Physician Signature:_____Date:_____

Physician Name:_____NPI#:_____

Address:_____