HORIZON PROSTHETICS

Dear Patient,

Your insurance provider requires that we collect specific documentation from you and your doctor to support medical necessity for therapeutic shoes and inserts.

Prior to scheduling your appointment, please obtain these supporting documents:

- **A Diabetic Footwear Prescription Form and Certifying Physician Form (Page 3 & 4).** This must be completed and signed by the physician who is treating your diabetes. **This physician must be an MD or DO.**

- **Clinical Evaluation/Notes (Acquire directly from your doctor, MD or DO).** Notes must document that the physician is treating your diabetes and the notes must indicate medical necessity for therapeutic shoes in the treatment of your diabetes with a foot examination. The evaluation must be within the last 6 months.

If you have not seen your diabetic physician within the last 6 months, you need to see them for a regular appointment and have an examination completed. Please bring these forms to your physician and have them filled out **entirely** before your appointment with us. Your doctor may fax the required documents directly to Horizon Prosthetics. Once we have received these documents, we will review them and contact you to schedule your evaluation appointment.

Please make sure your physician knows that they are welcome to contact us with any questions they may have regarding these forms.

Horizon Prosthetics
Ph: 303-660-1238
Fax: 303-872-6528

HORIZON PROSTHETICS

Dear Physician,

For an item addressed in this policy to be covered, a written signed and dated order must be received by Horizon Prosthetics with medical necessity stated in the patient's medical record.

The need for therapeutic shoes must be certified by a physician who is an M.D. or D.O. and who has the primary responsibility for treating the patient's systemic diabetes. This physician must:

1. Document in the patient's medical record that the patient has diabetes; and
2. Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
3. Document in the patient's medical record the presence of one or more of the following conditions:
   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of preulcerative calluses of either foot, or
   d. Peripheral neuropathy and evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation (i.e., small or large vessel arterial insufficiency) in either foot.

If criteria 1-3 are not met, the therapeutic shoes, inserts and/or modifications will be denied as noncovered.

It's important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed in 3a–3f is present. Please provide copies of those records.

Please sign, date, and fax the following attachments along with a letter of medical necessity and/or encounter notes as soon as possible so that we can being the order process.

Thank you,

Horizon Prosthetics
Phone: 303-660-1238
Fax: 303-872-6528

DIABETIC FOOTWEAR PRESCRIPTION FORM

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM - THIS PRESCRIPTION MUST BE ACCOMPANIED BY A SIGNED STATEMENT OF CERTIFYING PHYSICIAN. ***THE STATEMENT OF CERTIFYING PHYSICIAN MUST BE SIGNED BY THE MD OR DO TREATING THE PATIENT'S DIABETIC CONDITION****.*

Patient Name: _____ Patient Phone: _____

ICD 10 Code: ____.___

Check all that apply:

- ☐ 1 pair of diabetic shoes (A5500)
- ☐ 3 pairs of custom molded diabetic orthotics (A5513)
- ☐ Custom molded diabetic orthotics WITH TOE FILLER FOR AMPUTATION (L5000)
  (Specify quantity) Right Foot _____ Left Foot _____

***Medicare will cover one pair of either depth or custom molded shoes and six inserts (3 pair of either heat or custom molded) per calendar year. Medicare will not pay for extra items. Any additional products and services will be the financial responsibility of the patient.

RX Instructions: Wear items prescribed daily during waking hours.

PRESCRIBING PHYSICIAN INFORMATION

_____	_____
Physician Name - Printed	Physician Signature / Date
_____	_____
Physician Address	NPI
_____	_____
City / State / ZIP	Phone/ Fax

CERTIFYING PHYSICIAN FORM

NOTE. FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM - ***THIS DOCUMENT MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION AND THE STATEMENTS BELOW MUST BE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD - WHICH WE MUST ALSO RECEIVE A COPY OF TO VERIFY THE ITEMS BELOW.*** *THIS SCP MUST BE ACCOMPANIED BY A SIGNED DIABETIC FOOTWEAR PRESCRIPTION FORM.*

Patient Name: _____ Medicare#: _____

Patient Phone: _____ Date of Birth: _____

I certify that all of the following statements are true.

1. This patient has diabetes mellitus - ICD-10 Code: __ __ __ .__ __ **(Five digit ICD-10 Diagnosis Code Required E11.40- E11.9)**

2. This patient has one or more of the following condition **(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 (claw toe, hammer toe, Charcot arthroathy, bunions, hallux valgus, hallux rigidus)
   - ☐ Poor Circulation.

3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special depth shoes (depth or custom molded shoes) and for inserts because of his/her diabetes.
5. **The above information is documented in the patient's medical record**, **as Indicated in the attached clinical notes**.

CERTIFYING PHYSICIAN INFORMATION

_____ MD or DO _____

Physician Name – (Printed) (circle one) Physician Signature Date

_____ _____

Physician Address Physician NPI #

_____ _____

City / State / ZIP Physician Phone #