PROSTHETIC
ORTHOTIC
INSTITUTE

MEDICARE RULES FOR DIABETIC SHOES

PATIENT CHECKLIST

NO appointment can be made for diabetic shoes

until **you bring us the forms** below from your Primary Care Physician.

- Diabetic Verification Form, completed and signed by your Primary Care Physician (MD or DO)
    - Delivery has to take place within 3 months of date signed.
- Office Notes, (with foot exam noted) from your in-person or video visit with your Primary Care Physician (MD or DO)
    - Delivery has to be within 6 months of date signed.
- A prescription for Diabetic Shoes and inserts with diagnosis codes listed.

This is the ONLY way Medicare will pay for your diabetic shoes.

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Dear Valued POI Partner,

To better serve your patients:

Please provide your patient with the following information. Once they receive this information, ***they* will bring it to our office** for their appointment.

- Physician Progress Notes ***(include in your notes the diabetic foot condition(s)*** that you indicated on the Diabetic Verification Form **(must be signed by MD or DO))**
- Diabetic Verification Form **(must be signed by MD or DO)**
- Rx for Diabetic Shoes and Inserts ***with Diagnosis Codes***

Once the patient brings us this information, we will schedule their appointment and satisfy their needs quickly and efficiently.

Again, we are grateful for your business and appreciate your commitment to quality patient care.

Thank You,

Prosthetic & Orthotic Institute, Inc.

PROSTHETIC
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Diabetic Verification Form

Patient Name:_____ DOB:_____

I certify that all of the following statements are true:

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

___History of a partial or complete foot amputation

___History of a previous foot ulceration

___History of pre-ulcerative callus

___**Peripheral neuropathy **(must show with evidence of callus formation)**

___Foot deformity

___Poor circulation

3. I am treating this patient under a comprehensive plan of care for his/her/their diabetes.
4. The patient needs special shoes (depth or custom molded shoes) because of his/her/their diabetes.

_____ _____

Physician Signature Date Signed

_____ _____

Physician Name (printed) NPI

(Must be an M.D. or D.O.)

Physician Address: _____

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Pineville Office:
10502 Park Road, Suite 170
Charlotte, NC 28210
704-697-1105
Fax: 704-544-3438
www.poibelieve.com

Name: _____ Date: _____

Patient DOB: _____

Diagnosis: _____

℞

Signature: _____ M.D.

NPI#: _____

The above device for the patient is medically necessary.