EASTERN PEDORTHICS

MANDATORY STEPS NEEDED FOR MEDICARE BILLING:

1. A **WRITTEN PRESCRIPTION** from an M.D., D.O. or a Podiatrist

2. A **FULLY COMPLETED** Statement of Certifying Physician (CMN) from the doctor who is treating the diabetes This form is enclosed

3. A copy of at least one (1) page of notes, taken from patient's file, **SIGNED AND CORRESPONDING WITH THE PATIENT'S CONDITION LISTED ON THE CMN** (see step 2) from the doctor who is treating the diabetes. These must be copies of the actual patient notes within the last six months and not a summarized letter of patient history.

******* **NOTE** *******

All three (3) documentation requirements MUST BE received before we will evaluate the patient AND then follow-up with delivery of product.

7 Route 31 North, Pennington, NJ 08534
Phone (609)737-7701 Fax (609)737-7705

EASTERN PEDORTHICS

Dear Staff,

In order to have my Pedorthist provide me with therapeutic shoes and inserts under Medicare guidelines, **they must have a copy of the progress notes related to the physician's treatment of my diabetic condition that justifies the medical necessity for the referral to a Pedorthist for therapeutic shoes and inserts.** The copy of the progress notes from my current medical records validates that I am under a comprehensive plan of care for my diabetes for Medicare billing purposes. The copy of my progress notes must show that I have one or more of the following conditions:

1. Previous amputation of the foot, or part of either foot, or
2. History of previous foot ulceration of either foot, or
3. History of pre-ulcerative calluses of either foot, or
4. Peripheral neuropathy with evidence of the callus formation of either foot, or
5. Foot deformity of either foot, or
6. Poor circulation in either foot

Please note that this information is needed **in addition to** the **Statement of Certifying Physician (see attached) as well as a prescription.**

☐ Please fax a copy of the relevant progress note page(s) to:

Eastern Pedorthics	(609) 737-7705
Company	*Fax Number*

☐ I would like to pick these up in person.

☐ Please mail a copy to:

Eastern Pedorthics
7 Rt. 31 North
Pennington, NJ 08534

Thank you,

_____	_____	_____
Patient Name	*Patient Signature*	*Date*

_____	_____
Social Security Number	*Date of Birth*

Note: *If there are any questions about what is being requested, please call Eastern Pedorthics at (609) 737-7701.*

EASTERN PEDORTHICS

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

PATIENT'S NAME _____

MEDICARE NUMBER _____

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 (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

_____ 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'S NAME _____
(Printed – **MUST be an M.D. or D.O.**)

PHYSICIAN'S ADDRESS _____

_____

PHYSICIAN'S PHONE # _____

PHYSCIAN'S NPI # _____

PHYSICIAN'S SIGNATURE _____

DATE _____

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