

TAKE THIS TO YOUR PRIMARY CARE PHYSICIAN

## A Comprehensive Foot Health Program is an integral part of managing a patient's diabetes.

More than 60% of non-traumatic lower limb amputations are a result of diabetes.

The rate of amputation for people with diabetes is 10 times higher than for people without diabetes.

60-70% of diabetics have mild to severe forms of nervous system damage resulting in impaired sensation in the feet.

According to the CDC (Centers for Disease Control), comprehensive foot care programs can reduce diabetic foot amputations by as much as 85%.

For more information on diabetes and your feet, visit these sites:

[www.diabetes.org](http://www.diabetes.org)  
[www.drcomfort.com](http://www.drcomfort.com)

[www.cdc.gov](http://www.cdc.gov)  
[www.cms.gov](http://www.cms.gov)

### ATTENTION: PRIMARY CARE PHYSICIAN

Please fax completed forms  
AND YOUR PATIENT NOTES to:



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**Dr. Comfort**  
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comfort footwear

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## IMPORTANT MEDICARE DOCUMENTATION INSTRUCTIONS

Dear Doctor,

Just a few minutes of your time could help protect me against the foot health issues associated with diabetes – such as foot ulcerations or amputation.

# Dr. Comfort

**NOTE: Most recent office visit to Primary Care Physician must be within 6 months of patient receiving diabetic shoes and inserts.**

To be completed by the M.D. or D.O. managing the patient's systemic diabetes condition in order for the patient to receive the Medicare benefit for prescription diabetic shoes and inserts under the Therapeutic Shoes for Persons with Diabetes (TSPD) Act.

Providing this benefit for your patient is as easy as

## One, Two, Three...

### One

Complete the **Statement of Certifying Physician** confirming the patient meets Medicare's criteria—they have diabetes and one of the six qualifying conditions listed on the Statement.

### Two

Complete the **Prescription for Diabetic Shoes and Inserts**, along with any special instructions.

### Three

Provide a copy of your **Patient Notes**—the sections showing 1) diagnosis of the qualifying condition and 2) treatment of the patient's diabetes.

**Return these three documents to the patient or simply fax them to the provider listed on the back of this brochure. If you have any questions, please contact the provider for assistance.**

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## Statement of Certifying Physician

Patient: \_\_\_\_\_

Patient D.O.B.: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

- 1) This patient has diabetes mellitus:
- Type II       Type I
- 2) **QUALIFYING CONDITIONS:** I have diagnosed and am including my notes showing that this patient has one or more of the following:
- 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 for care of his/her diabetes.
- 4) This patient needs special shoes (extra depth or custom molded) because of his/her diabetes.
- 5) This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physician Signature: \_\_\_\_\_ Must be an M.D. or D.O.

Physician Name: \_\_\_\_\_

NPI #: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

**FAX THIS AND YOUR PATIENT NOTES TO THE NUMBER ON THE BACK OF BROCHURE...**

## Prescription for Diabetic Shoes and Inserts

Patient: \_\_\_\_\_

Patient D.O.B.: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

- 1) Type of shoes prescribed (check):
- Extra Depth (A5500) - 1 pair, unless otherwise noted
- 2) Type of inserts prescribed (check one):
- Heat Moldable (A5512) - 3 pairs, unless otherwise noted
- Custom Fabricated (A5513) - 3 pairs, unless otherwise noted

ICD Notes and/or Special Instructions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Must be an M.D., D.O., D.P.M., P.A., N.P. or Clinical Nurse Specialist

Physician Name: \_\_\_\_\_

NPI #: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

**...OR GIVE THIS AND YOUR PATIENT NOTES BACK TO THE PATIENT. THANK YOU!**

(TEAR OFF HERE FOR FAXING)