GENUINE®
Dr.Comfort
EST. USA

Check 7

TEMPLATES PACKET

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T 800.556.5572 F 262.242.9300

DJO, LLC
5919 Sea Otter Place, Suite 200 I Carlsbad, CA 92010 I U.S.A.
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MKT00-8524 Rev E

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REQUEST FOR DOCUMENTATION FROM CERTIFYING PHYSICIAN

GENUINE® Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
MBI	RECORD ID
TODAYS DATE	

Re: Diabetic Footwear Documentation Request

Dear Dr. _____

I am writing to request your assistance in providing the above patient with diabetic footwear, as provided under the Therapeutic Shoes for Persons with Diabetes Act (TSPD) SSA 1861 (s)2. In order to qualify for Medicare reimbursement, your certification that they meet certain conditions is required, as well as a prescription for diabetic shoes and inserts.

May I ask you to please review and complete the attached forms as follows:

☐ Statement of Certifying Physician - complete, sign and date

☐ Copy of your patient notes indicating:

a. Management of the Diabetes and last visit

Copy of your notes:

☐ Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement;

- or -

☐ Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/ inserts, and that documents one of more of criteria a – f.

Fax or email these back to us at: _____

Please do not hesitate to call me at _____ if you have any questions. I greatly appreciate your assistance in serving the needs of this patient.

Sincerely,

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STATEMENT OF CERTIFYING PHYSICIAN

GENUINE Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

I hereby certify that the patient mentioned above:

1. Has Diabetes
   - ☐ Type I (ICD-10 Code(s): _____)
   - ☐ Type II (ICD-10 Code(s): _____)
2. This patient has the following conditions (check all that apply):
   - ☐ a. History of partial or complete amputation of the foot
   - ☐ b. History of previous foot ulceration
   - ☐ c. History of pre-ulcerative callus
   - ☐ d. Peripheral neuropathy with evidence of callus formation
   - ☐ e. Foot deformity
   - ☐ f. 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 SIGNATURE	DATE
PHYSICIAN NAME	NPI#

PHYSICIAN ADDRESS

CITY	STATE	ZIP CODE

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“INCIDENT TO” REQUIREMENT

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Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

I have documented in the medical record that the patient is diabetic, and I continue to provide follow-up under a comprehensive management program. I have reviewed and verified the medical records pertaining to the provision of therapeutic shoes and inserts and agree with the action, assessment, findings, and treatment plan of the NP/PA.

NP/PA name: _____

PHYSICIAN SIGNATURE	DATE
PHYSICIAN NAME	NPI#

PHYSICIAN ADDRESS

CITY	STATE	ZIP CODE

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CERTIFYING PHYSICIAN ATTESTATION PRESCRIBING PHYSICIAN'S NOTES

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Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

Patient Notes Including Diagnosis of Qualifying Condition

Examining Physician Signature:

SIGNATURE

PRINT NAME	DATE

Attesting Physician Signature: I have reviewed the above diagnosis and agree with the findings. I am including a copy of this diagnosis in the patient's file.

SIGNATURE

PRINT NAME	DATE

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STANDARD WRITTEN ORDER

GENUINE® Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

TODAY'S DATE

Check all that apply

- ☐ DIABETES MELLITUS
- ☐ CALLUS(ES)
- ☐ CORN(S)
- ☐ ULCER(S)
- ☐ HAMMERTOE(S)
- ☐ AMPUTATION(S)
- ☐ POOR CIRCULATION
- ☐ OTHER:
- ☐ BUNION(S)
- ☐ CHARCOT DEFORMITY
- ☐ NEUROPATHY WITH EVIDENCE OF CALLUS FORMATION

Others

THE PATIENT REQUIRES

☐ THERAPEUTIC FOOTWEAR, NON-CUSTOM (A5500) - 1 PAIR (UNLESS OTHERWISE INDICATED)
WITH (SELECT ONE OPTION FROM BELOW)

☐ NON-CUSTOM, HEAT MOLDABLE (A5512) – 3 PAIRS (UNLESS OTHERWISE INDICATED)

☐ CUSTOM MOLDED INSERTS (A5513/A5514) – 3 PAIRS (UNLESS OTHERWISE INDICATED)

- ☐ LESIONS REQUIRING OFFLOADING (IF NECESSARY) L ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
  R ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ TOE FILLER (L5000)

- ☐ INDICATE MISSING DIGITS L ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
  R ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

COMMENTS

Prescriber's Name

PRESCRIBING PHYSICIANS NAME

SIGNATURE	DATE

NPI# OF ORDERING ENTITY (M.D./D.O./DPM/PA/CNS/NP)

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DOCUMENTATION OF INITIAL IN-PERSON ASSESSMENT

GENUINE® Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID
MET WITH PATIENT IN-PERSON ON (DATE)	AT THE FOLLOWING LOCATION

Comments

OBJECTIVE ASSESSMENT OF THE FEET

DIAGNOSIS-SPECIFIC ISSUES FROM PRESCRIPTION TO BE CONSIDERED

ACTIONS TAKEN DURING TODAY'S VISIT

PLAN

Patient Shoe Fitting Info

DATE OF FITTING	CURRENT SIZE & WIDTH

	RIGHT FOOT	LEFT FOOT	COMMENTS
1. HEEL TO TOE			
2. HEEL TO BALL			
3. MIDPOINT OF 1 & 2			
4. WIDTH			

*CONSIDER THE BETTY, DOUGLAS, EDWARD X, LUCIE X, MAGGY X, WILLIAM X, WINNER X OR SPIRIT X **CONSIDER THE RANGER, VIGOR OR BOSS ***CONSIDER THE ANNIE, BRIAN OR MERRY JANE LYCRA

MIDPOINT MEASUREMENT IS THE SIZE THAT IS HALFWAY BETWEEN HEEL TO TOE AND HEEL TO BALL TO THE CLOSEST FULL OR HALF SIZE, BUT NEVER MORE THAN ONE FULL SIZE GREATER THAN HEEL TO TOE MEASUREMENT. USE THE MIDPOINT TO DETERMINE WIDTH SIZE. TRY A SHOE ON CLOSEST TO THIS MEASUREMENT (MIDPOINT AND WIDTH)

NAME	COLOR	SIZE	WIDTH

Pairs of Inserts

☐ 1	☐ 2	☐ 3

FITTER NAME

FITTER'S SIGNATURE	DATE

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DOCUMENTATION OF IN-PERSON FITTING AT TIME OF DISPENSING

GENUINE® Dr.Comfort EST. USA

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID
MET WITH PATIENT IN-PERSON ON (DATE)	AT THE FOLLOWING LOCATION

ITEMS BEING DISPENSED

Comments

SUPPLIER'S OBJECTIVE COMMENTS REGARDING FIT OF SHOES

SUPPLIER'S OBJECTIVE COMMENTS REGARDING FIT OF INSERTS AND ANY ACCOMODATIONS MADE AT THE TIME OF DISPENSING

FOLLOW-UP INSTRUCTIONS TO PATIENT AND PLAN OF CARE NOTES

FITTER'S SIGNATURE

PRINT NAME	DATE

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AUTHORIZATION OF PAYMENT AND WARRANTY

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Patient Info

PATIENT NAME	DATE OF BIRTH	
PATIENT MBI#	RECORD ID	
DELIVERY ADDRESS		
CITY	STATE	ZIP CODE

I have received _____(enter "2" for a pair) individual Dr. Comfort®

(Style: _____ Color: _____ Size: _____Width: _____) "extra depth" shoes and (choose one below):

☐ _____(enter "6" for 3 pairs) individual Dr. Comfort® full contact custom therapeutic inserts (A5513/A5514 PDAC compliant).

☐ _____(enter "6" for 3 pairs) individual Dr. Comfort® therapeutic inserts (A5512 PDAC compliant).

Authorization

I authorize Medicare and my supplemental insurance to pay _____directly, as I am satisfied with the fit of the shoes and inserts I received. I understand Medicare may reimburse for up to one pair of shoes (2 individual) and 3 pair of inserts (6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare and/or my co-insurance does not cover. I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.

Patient's Warranty Statement: Our office will accept returns of any Dr. Comfort® shoes, for any reason within thirty days of the shoes being dispensed. If, within thirty days, we determine the shoes do not fit properly, we will replace them at no extra charge with a properly fitted shoe. Dr. Comfort® shoes that have been dispensed for a period of over thirty days will only be exchanged or credited at our discretion. Any shoes that are returned must be returned in the original, unaltered shoe box.

Supplier Standards and Break-in Procedure: The Supplier has provided me with current, written copies of the Medicare DMEPOS Supplier Standards, and Footwear Instructions. The supplier has educated me on the proper break-in procedure for my Dr. Comfort® shoes. The Supplier has also provided me with a "complaint protocol" to resolve any further disputes regarding the products dispensed.

PATIENT SIGNATURE	DATE

If someone other than the Medicare beneficiary signs, the relationship between the person signing and the beneficiary and the reason the beneficiary was unable to sign must be indicated.

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