STUBBS
PROSTHETICS & ORTHOTICS, INC.

Therapeutic Shoes (Diabetic Shoes) Patient Paperwork Steps

Dear Patient,

Your insurance requires paperwork to support medical necessity for therapeutic shoes and inserts. Please complete the following:

📜 Step 1: Take This to Your Doctor

- Bring this shoe packet to the doctor who is treating your diabetes.

✍️ Step 2: Doctor Fills Out Forms

Ask your doctor to complete:

- **Statement of Certifying Physician** saying you need the shoes.
- **Initial Prescription** for diabetic shoes and inserts.
- **Clinical Notes** from your doctor's appointment.

⚠️ Important Additional Information ⚠️

- *Appointments must be within the last **6 months.***
- *Notes must document you have diabetes.*
- *You must have a foot condition that qualifies you for diabetic shoes.*
- *Notes must document a foot exam and that you need diabetic shoes.*
- *All forms and notes must be signed by a **medical doctor (MD or DO).***

📩 Step 3: Send Paperwork Back

- Your doctor can fax it, or you can bring it into one of our offices.

📞 Step 4: Wait for Our Call

- We will review your paperwork
- If approved, we will call you to schedule an appointment.

💬 Questions? Call us — we are happy to help!

- Chattanooga Office Phone: (423) 698-1778 FAX: 423-698-7642
- Dalton Office Phone: (706) 259-4563 FAX: 706-259-4775

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Statement of Certifying Physician for Therapeutic Shoes

To be completed by the certifying physician

Patient Name: _____

DOB: _____ Medicare/Ins ID: _____

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 for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Signature, name, date, and NPI (must be an M.D. or D.O.)

Physician Name: _____

Address: _____

City_____State: _____ Zip: _____

Phone# _____Fax# _____ NPI: _____

Physician Signature: _____ Date Signed: _____

(If a nurse practitioner, physician assistant or clinical nurse specialist is treating the patient complete, sign and date below.)

Practitioner name: _____ NPI: _____

Practitioner Signature: _____ Date Signed: _____

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Initial Prescription for Therapeutic Shoes for Diabetes

Payer requires <u>all fields</u> to be completed by the <u>ordering practitioner.</u>

Patient name: _____ DOB: _____

Date of Order: _____ Diagnosis: _____

DIABETIC SHOES & INSERTS

Additional Instructions: _____

<u>Ordering Practitioner Information</u>:

Name (Printed): _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____ Phone# _____ Fax# _____

Signature: _____ **Date:** _____