FOOT COMFORT CENTER

NORTHEAST PHILA. 9808 Bustleton Avenue Philadelphia, Pa 19115 **215-676-7463**	**FRANKFORD** 4733 Frankford Avenue Philadelphia, Pa 19124 **215-744-7463**	**BROAD & OLNEY** 1335 W. Tabor Road, Ste. 107 Philadelphia, Pa 19141 **215-548-7463**	**SOUTH PHILA.** 1937 E. Passyunk Avenue Philadelphia, Pa 19148 **215-334-7463**
CENTER CITY 303 Market Street Philadelphia, Pa 19106 **215-733-9902**	**WARRINGTON** 1380 Easton Road Warrington, PA 18976 **215-491-7467**	**SOUTHWEST PHILA.** 6113 Woodland Avenue Philadelphia, Pa 19142 **215-724-7464**	**NORTH PHILA.** 2917 N. 5th Street Philadelphia, Pa 19133 **215-739-7463**

Dear Doctor,

Your patient has requested us to invoice his/her health insurance company for his/her diabetic footwear and appropriate multi-density insoles. In order for us to accommodate your patients' needs, proper documentation must be provided. Please note that it is required by Medicare that ALL documentation be available in patients' records. If requested by the supplier, copies of those records must be provided. Also, please be aware that medical records of the patient may be requested upon Medicare's review. Therefore, documenting detailed information about the patient's condition and management of his or her diabetes is mandatory according to Medicare's policy.

Please fill out and SIGN the Statement of Certifying Physician for Therapeutic Shoes. Also, please provide an original prescription OR complete and SIGN the Prescription Form that is provided on the bottom of this page.

Thank you - Sofya Tamarkin, Board Certified Pedorthist

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient name: ____ Patient Tel. #:________________________

By signing this statement, I certify that all of the following statements are true:

1. The patient has diabetes mellitus (ICD-9 diagnosis codes 249.00-250.93); and

2. The patient has one or more of the following conditions (***circle all that apply***):
   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy with evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation in either foot; and

3. The certifying physician who is managing the patient's systemic diabetes condition has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

Physician signature:____ Date signed: ______________________

Physician name (printed):____ Physician NPI:____________________

Physician address:____ Telephone #________________________

PRESCRIPTION FORM

Patient Objectives: To transfer forces from high to low pressure areas, provide protection for the insensitive diabetic foot, absorb shock, reduce shear, and maximize comfort. Other objectives: ____

In order to meet these objectives, ____requires
Patient Name

- Depth Inlay Shoes with Multi-Density Inserts (*Medicare allows 1 pair of depth shoes & 3 pairs of Multi-Density Inserts per year)

If other (please specify): ____

Physician signature: ____ Date signed: ____________________________

OUR FAX NUMBER IS 215-676-1110