Rocco Prosthetic &
Orthotic Center, Inc.

Dear Doctor,

Our mutual patient is interested in receiving diabetic shoes and inserts.

For insurance purposes a diabetic foot exam must be completed on the patient within the past 6 months.

Please see questionnaire below and follow accordingly.

**Has a diabetic exam been completed on the patient within the past 6 months?**

**YES**

- ☐ - Complete Pages 2 and 3 of packet
- ☐ - Fax us the completed pages & diabetic foot exam notes

**NO**

- ☐ - Schedule a diabetic foot exam appointment with the patient
- ☐ - Once an exam has been completed follow steps above

Feel free to give our office a call if you have any questions.

513-281-2800

Thank you!

2375 Florence Avenue, Cincinnati, Ohio 45206
Phone: 513-281-2800 Fax: 513-281-0420 Toll Free: 888-281-1007

Rocco Prosthetic & Orthotic Center, Inc.

## STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

**To be completed by an M.D. or D.O. only.**
**Please attach office notes pertaining to last date seen for diabetic exam.**

**Patient's Name:** ______________________________ **D.O.B.:** ______________

I certify that all of the following statements are true:

1) This patient has diabetes mellitus - **ICD-10 Code:** ______________________________
**(Please fill in, using appropriate ICD 10 HCPC code.)**

2) **(Please circle all (A-G) that apply below)** This patient has one or more of the following conditions:

*A)* History of partial of 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.
*G)* None of the Above (Disqualifies patient for Medicare TSB Coverage).

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.

**Last Date Seen for Diabetic Exam** (valid for 6 months): ______________________________
(please send these notes)

**Physician's Signature** (Signature stamps are not accepted): ______________________________

**Date Signed** (valid for 3 months): ______________________________

**Print Physician's Name:** ______________________________ **NPI #:** ______________

**Physician's Address:** ______________________________

**Physician's Phone Number:** ______________________________ **Fax:** ______________

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## Prescription-Letter/Certificate of Medical Necessity

Patient Name: ______________________________ Patient Date of Birth: ______________________

Prescriber's Name and Address:

Name: ____________________________________

Address: __________________________________

Prescriber's Phone and Fax Number

Phone: ______________________________

Fax: _________________________________

Prescriber's NPI:

_________________________________

Diagnosis (ICD 10 Code):

_________________________________

Side: Bilateral

Description of item/services ordered:

☐ 2 shoe, diabetic, off- the-shelf, depth-inlay, per shoe and 2 custom molded multi-density inserts

☐ Other:_________________________________________________________________

Prescription date (Start date):

_______________________

Expected length of need:

_______ ____________________

I authorize the items/services shown above and certify that the information provided herein is true and accurate.

_________________________________________ ____________________________

Prescriber's Signature (Please physically sign)

Date (Please physically date)

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An ABC Accreditied Facility offering Advanced Prosthetic, Orthotic and Pedorthic Procedures Since 1992