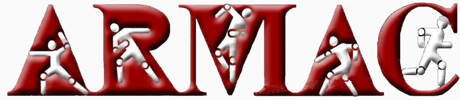

Thank you for choosing Armac for your care related to Therapeutic Shoes and/or Inserts! Your insurance requires specific documentation from your doctor(s) to support the medical necessity of this service and ensure claim payment.

Prior to scheduling an appointment, please obtain following supporting documents:

A Written Prescription Order from an MD, DO or a Podiatrist

- This document must be completed and signed by the physician who is prescribing you the shoes/inserts & specifying what is being ordered with the appropriate diagnoses.
- This physician may be an MD, DO, DPM, NP or PA

A Certifying Statement for Therapeutic Shoes(See Attached Form)

- This document must be completed and signed by the physician who is treating your diabetes.
- This physician must be an MD or DO only
- Must be dated within 3 months prior to you receiving shoes/inserts

Clinical Evaluation/Office Visit notes from your physician(s)

*This documentation may either be faxed over to us directly or printed and provided to you.

From the ordering physician *who writes the prescription*

- Must be documented that you need diabetic shoes/inserts, the medical necessity for it and that you will benefit from the diabetic footwear.

From the certifying physician *who treats your diabetes.*

- Must explicitly state that they are treating your diabetes
- Must explicitly state the options they selected in the Statement above, and a documented foot exam.
- Must mention that you need diabetic shoes/inserts and document the reason for it.
- Must be within 6 months prior to you receiving shoes/inserts.

➢ *If you haven't been seen by them within the past 6 months, please make an appointment to be examined for your diabetes, feet, and the need for shoes and inserts.*

Once all documentation has been received by us we will review them and contact you to schedule your evaluation appointment.

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Information

Last Name:______________________ First Name: ___________________ MI:____

DOB(MM/DD/YYYY):__________________ Sex: Female/Male/Other

MEDICARE/INS ID:______________________

I certify that all of the following statements are true:

1.)This patient has diabetes mellitus. Diagnosis Code(s):______________

2.)This patient has **one or more of the following conditions**(check all that apply):

- ☐ Foot deformity
- ☐ Previous partial amputation of one or both feet or complete amputation of one foot
- ☐ Current or previous foot ulceration
- ☐ Current or previous pre-ulcerative calluses
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Poor circulation in one or both feet

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) and or inserts because of his/her diabetic condition.

The above information is documented in the patient's medical record.

Certifying Physician Information (must be an MD or DO)

Signature*:__________________________________Date Signed*:_____________

Name(Printed):_______________________________________

Address:____

City, State, Zip:____________________________________

Work Phone:_______________________________________

Fax:____

Physician NPI:______________________________________