Diabetic Shoe Documentation Needed

For the Patient: Take this Packet to Your Doctor's Appointment

- Bring this packet to your provider and ensure all sections are completed. Your provider may submit documents directly or return them to your local Hanger Clinic.

Patient Name: _____ **DOB:** _____

Local Hanger Clinic / Fax: _____

Dear Provider,

We recently received a request for a mutual patient. To help prevent delays and support Medicare documentation requirements, please review the items below and complete all applicable sections before returning the packet.

1. Standard Written Order (SWO)

- Must be completed by the prescribing provider (MD, DO, DPM, NP, or PA).

2. Clinical Evaluation / Notes (Within 6 Months)

A. Diabetes Management Visit (MD/DO REQUIRED)

- Must document ongoing management of diabetes.
- If signed by NP/PA: MD/DO must co-sign, date, and indicate agreement.
- DPM notes cannot be used for diabetic management; MD/DO note required.

B. Foot Exam with Qualifying Condition

- Must document foot exam plus qualifying condition.
- If signed by DPM/NP/PA: MD/DO must co-sign, date, and indicate agreement.

3. Statement of Certifying Physician (SCP)

- Must be signed and dated by MD/DO only.
- Must be dated ON or AFTER MD/DO-signed notes.
- Must be within 3 months prior to delivery.
- Confirms diabetes, qualifying condition, and medical necessity.

Items to send with this packet:

- ☐ Pt. Demographic Sheet
- ☐ SWO completed
- ☐ Clinical notes included
- ☐ SCP completed

Please submit completed documentation to your local Hanger Clinic.

Therapeutic Shoes for Persons with Diabetes Statement of Certifying Physician

All fields are required by payer to be completed by the certifying physician

Patient Name: _____ **DOB:** _____

Medicare/ID: _____ **Last Foot Exam:** _____

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.)

Name (Printed): _____ **Credential:** ☐ MD ☐ DO

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **FAX:** _____

NPI: _____

Signature: _____ **Date:** _____

Please fax completed forms to your patient's Hanger Clinic.

Standard Written Order for Therapeutic Shoes for Diabetes

All fields are required by payer to be completed by the certifying physician

Patient Name: _____ **DOB:** _____

Date of Order: _____ **Diagnosis:** _____

Shoes

QTY: _____ ☐ Extra Depth ☐ Custom Molded

Inserts

Pairs: ☐ 1 ☐ 2 ☐ 3

	Left	Right
Toe Filler	☐	☐
Prefabricated	☐	☐
Custom Fabricated	☐	☐

Other: _____

Additional Instructions:

_____

Ordering Physician Information

Name (Printed): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

FAX: _____ **PHONE:** _____

NPI: _____

Physician Signature: _____ **Date:** _____

Please fax completed forms to your patient's Hanger Clinic.