Hanger CLINIC
Empowering Human Potential

Dear Patient,

The requested below information is a requirement of your insurance provider. Your insurance provider requires that we collect specific documentation from you and your providers to support medical necessity for therapeutic shoes and inserts. **Please take this packet to your appointment and have your Physician complete all required paperwork:**

- **Statement of Certifying Physician for Therapeutic Shoes**
- **Prescription/Standard Written Order**
- **Office Visit Notes** from prescribing provider and physician that treats your diabetes. These evaluations must be within 6 months prior to receiving your shoes and/or inserts. The Statement of Certifying Physician form must be completed by the physician that treats your diabetes.

Your doctor may fax the required documentation directly to your local Hanger Clinic or you may bring it in. Once we receive these documents, we will review them and if they meet insurance requirements, we will call you to schedule your evaluation/fitting appointment. **If you have any questions regarding your therapeutic shoe needs, please contact the closest Hanger Clinic.**

Find your local Hanger Clinic's contact information: **HangerClinic.com/Locations**

----------***Instructions to take to Provider***----------

Dear Physician,

Please assist us in providing our mutual patient with diabetic shoes and inserts. Medicare/Insurance states that they need the following documentation from the certifying physician:

☐ **Prescription/Standard Written Order**

- The ordering provider can be doctor, podiatrist, nurse practitioner, physician assistant or clinical nurse specialist.
- The Standard Written Order must be completed by the prescribing provider.

☐**Clinical Evaluation/Notes**

- A copy of an office visit note, from the patient's medical record, that shows management of the patient's diabetes. This office visit **must occur within 6 months prior to delivery** of the shoes and inserts.
- A copy of an office visit note, from the patient's medical record, that **must** document a foot exam with a qualifying foot condition. The evaluation **must be within 6 months** prior to the patient receiving shoes and/or inserts. This interaction can be between:
  (a) The patient and the certifying physician *or*
  (b) The patient and another qualified practitioner (such as a podiatrist, NP, PA, or certified nurse specialist [CNS]).
  If option (b) is used, then the certifying physician must sign, date, and make a note on that document indicating agreement and send that to the supplier.

☐ **Statement of Certifying Physician for Therapeutic Shoes**

- This form must be completed, signed, and dated by the certifying physician on the same day or after the date of the office visits described above within 3 months prior to delivery. **This physician must be an MD or DO.**
- This document certifies the patient's diagnosis of diabetes, and that the patient has a qualifying condition necessitating treatment with therapeutic shoes as part of their comprehensive plan.

***If the Statement or Diabetic Management Notes are authored/signed/completed by NP or PA, the supervising MD/DO the NP or PA works incident to must review and verify (sign/date) acknowledging agreement with the NP or PA.*

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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/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.)

Name (Printed): _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____

Signature:_____ Date:_____

Please fax completed forms to your patient's Hanger Clinic.
HangerClinic.com/Locations

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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 (please circle) 1 2 3

- Toe Filler Left Right
- Prefabricated Left Right
- Custom Fabricated Left Right
- Other: _____

Additional Instructions: _____

_____

Ordering Physician Information

Name (Printed): _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____

Signature: _____ **Date:** _____

Please fax completed forms to your patient's Hanger Clinic.
HangerClinic.com/Locations