

A Comprehensive Foot Health Program is an integral part of managing a patient's diabetes.

More than 60% of non-traumatic lower limb amputations are a result of diabetes.

The rate of amputation for people with diabetes is 10 times higher than for people without diabetes.

60-70% of diabetics have mild to severe forms of nervous system damage resulting in impaired sensation in the feet.

According to the CDC (Centers for Disease Control), comprehensive foot care programs can reduce diabetic foot amputations by as much as 85%.

For more information on diabetes and your feet, visit these sites:

www.diabetes.org
www.drcomfort.com

www.cdc.gov
www.cms.gov

TAKE THIS TO YOUR PRIMARY CARE PHYSICIAN

ATTENTION: PRIMARY CARE PHYSICIAN

Please fax completed forms
AND YOUR PATIENT NOTES to:

Erickson Home Medical
8 South Main St.,
Clintonville WI 54929
Fax: 715-823-1322

Pharmacy 715-823-2222
M-Fr 9am - 6pm
Sat 9am - 1pm
HME 715-823-2106
M-Fr 8am - 5pm
Sat 9am - 12pm



We carry
Dr. Comfort
for the finest quality in
comfort footwear

Healthier, happier feet start here.



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TAKE THIS TO YOUR PRIMARY CARE PHYSICIAN

IMPORTANT MEDICARE DOCUMENTATION INSTRUCTIONS

Dear Doctor,

Just a few minutes of your time could help protect me against the foot health issues associated with diabetes – such as foot ulcerations or amputation.

Dr. Comfort

NOTE: Most recent office visit to Primary Care Physician must be within 6 months of patient receiving diabetic shoes and inserts.

To be completed by the M.D. or D.O. managing the patient's systemic diabetes condition in order for the patient to receive the Medicare benefit for prescription diabetic shoes and inserts under the Therapeutic Shoes for Persons with Diabetes (TSPD) Act.

Providing this benefit for your patient is as easy as

One, Two, Three...

One

Complete the **Statement of Certifying Physician** confirming the patient meets Medicare's criteria—they have diabetes and one of the six qualifying conditions listed on the Statement.

Two

Complete the **Prescription for Diabetic Shoes and Inserts**, along with any special instructions.

Three

Provide a copy of your **Patient Notes**—the sections showing 1) diagnosis of the qualifying condition and 2) treatment of the patient's diabetes.

Return these three documents to the patient or simply fax them to the provider listed on the back of this brochure. If you have any questions, please contact the provider for assistance.

To be completed by the M.D. or D.O. managing the patient's systemic diabetes condition in order for the patient to receive the Medicare benefit for prescription diabetic shoes and inserts under the Therapeutic Shoes for Persons with Diabetes (TSPD) Act.

Statement of Certifying Physician

Patient: _____

Patient D.O.B.: _____ Patient Phone: _____

- 1) This patient has diabetes mellitus:
- Type II Type I
- 2) **QUALIFYING CONDITIONS:** I have diagnosed and am including my notes showing that this patient has one or more of the following:
- 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 care of his/her diabetes.
- 4) This patient needs special shoes (extra depth or custom molded) because of his/her diabetes.
- 5) This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physician Signature: _____ Must be an M.D. or D.O.

Physician Name: _____

NPI #: _____ Date: _____

Physician Phone: _____

Physician Address: _____

FAX THIS AND YOUR PATIENT NOTES TO THE NUMBER ON THE BACK OF BROCHURE...

Prescription for Diabetic Shoes and Inserts

Patient: _____

Patient D.O.B.: _____ Patient Phone: _____

- 1) Type of shoes prescribed (check):
- Extra Depth (A5500) - 1 pair, unless otherwise noted
- 2) Type of inserts prescribed (check one):
- Heat Moldable (A5512) - 3 pairs, unless otherwise noted
- Custom Fabricated (A5513) - 3 pairs, unless otherwise noted

ICD Notes and/or Special Instructions:

Physician Signature: _____ Must be an M.D., D.O., D.P.M., P.A., N.P. or Clinical Nurse Specialist

Physician Name: _____

NPI #: _____ Date: _____

Physician Phone: _____

Physician Address: _____

...OR GIVE THIS AND YOUR PATIENT NOTES BACK TO THE PATIENT. THANK YOU!

(TEAR OFF HERE FOR FAXING)