Thank you for choosing Burton Prosthetics. We look forward to caring for you.

Your insurance provider requires that we collect specific documentation from you and your doctor to support medical necessity for therapeutic shoes and inserts.

Prior to scheduling your appointment, please obtain these three supporting documents:

- **A Statement of Certifying Physician for Therapeutic Shoes (Page 2)**
  - This document certifies your need for therapeutic shoes.
  - This must be completed and signed by the physician who is treating your diabetes. ***This physician must be an MD or DO***.

- **A Standard Written Order (Page 3)**
  - This document specifies the item(s) that the ordering provider is requesting be provided to you.. I
  - The ordering provider can be your doctor, podiatrist, nurse practitioner, physician assistant or clinical nurse specialist.

- **Clinical Evaluation/Notes (Acquire directly from you doctor)**
  - Your doctor can print and provide to you or fax to our office.
  - Notes must document that the physician is treating your diabetes and must be from the same physician that completes the Statement of Certifying Physician noted above. I
  - Notes must indicate medical necessity for therapeutic shoes in the treatment of your diabetes.
  - The evaluation must be within 6 months prior to receiving your shoes and/or inserts. '

If you have not seen your diabetic physician within the last 6 months, you will be required to schedule an appointment to have the examination completed. Your doctor may fax the required documentation directly to Burton Prosthetics or you may bring it in. Once we receive these documents, we will review them and call you to schedule your evaluation/fitting appointment.

Please note, the requested information is a requirement of your insurance provider. If you have any questions, please contact Burton Prosthetics

Therapeutic Shoes for Persons with Diabetes
Statement of Certifying Physician

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

Last name: ______________________ First name: ____________________ MI: ____

DOB: ____________ Gender: M__ F__

Medicare/Ins Policy ID: ________________ Date of Last Diabetic 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.)

Signature: ____

Name (Printed): ____

Address: ____

____

City: _________________________________ State: _____________ Zip: __________

Date: _________________ NPI: _______________________________

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 '

- Extra Depth Left Right
- Custom Molded Left Right

Inserts

Pairs (please circle) 1 2 3

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

Additional Instructions: ____

____

Ordering Physician Information

Signature: ____

Name (Printed): ____

Address: ____

____

City: __________________________________ State: _____________ Zip: __________

Date: __________________ NPI: _________________________________

Please fax completed forms to Burton Prosthetics. 402-384-1331