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1300 44th Street SE
Everett, WA 98203
Phare 425-339-2559
Fax425-339-1583

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3106 NW Ave
Bellingham, WA 98225
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1520 Roosevelt Ave
Mt. Vernon, WA 98273
Phone 360-416-6505
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7631 212th Street SW, STE 102A
Edmonds, WA 98026
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566 N Fifth Ave
Sequim, WA 98382
Phone 360-797-1001
Fax-360-797-1003

CORNERSTONE PROSTHETICS AND ORTHOTICS
Instructions for Receiving Therapeutic Footwear for Diabetics from Medicare

Welcome to Cornerstone Prosthetics and Orthotics. We are excited to provide you with proper fitting therapeutic footwear to prevent skin breakdown and ulceration. Please follow these instructions so that we can expedite the process of providing you with your new shoes.

We are contracted and/or authorized billers with the several medical insurance companies and state and federal programs. For information about their rules and regulations regarding coverage of pedorthic devices (orthotics, ankle/foot orthoses, diabetic footwear, shoe modifications, etc.), co-payments, and deductibles, please contact them directly.

While we do provide some paperwork and documentation guidance, we cannot guarantee payment by any insurance company or program. The patient is ultimately responsible for final payment at time of service due to any insurance denial, partial coverage or non-coverage.

A prescription from your primary care physician is the main document necessary in order to be considered for billing procedures. With some insurances or programs, additional documentation is necessary. We are always happy to perform a complimentary billing to insurance companies we are not contracted with on your behalf for your possible future reimbursement of services.

PATIENT INSTRUCTIONS

STEP ONE
Make an appointment with the doctor (MD or DO) who manages your diabetes and ask for a Diabetic Foot Examination. Medicare will not cover referrals from ARNPs, Physician's Assistants, Podiatrists or any healthcare provider who is not the MD or DO who manages your diabetes.

STEP TWO
Complete the top sections of page 2 and 3 of this document with your name, date of birth, and phone number. Then, bring this to your doctor appointment.

STEP THREE
Once we receive the request from your doctor, we will call you to schedule an appointment with one of our providers. If you do not hear from us within one week of your doctor appointment, please call us at your preferred location.

PHYSICIAN INSTRUCTIONS

STEP ONE
Complete the Prescription for Diabetic Shoes and Inserts (page 2), along with any special instructions. Do not leave any section blank. These forms are only for diabetic patients. **Visit Notes & Paperwork must be dated within 3 months.**

STEP TWO
Complete the Certificate of Medical Necessity (page 3) to confirm that the patient meets Medicare's criteria. The patient must be diabetic and have one or more of the qualifying conditions listed on the statement.

STEP THREE
(For Medicare and RegencePatients Only)
Provide a copy of your Patient Notes. The sections must show the diagnosis of the qualifying condition and the treatment of the patient's diabetes. Fax RX, CMN, and supporting chart notes to the fax number listed on each page.

Form 1 of 2
PLEASE FAX TO: 425-339-1583

Medicare Certification Statement for Therapeutic Footwear

The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician.

Patient Name:_____ Date of Birth:_____

Address:_____
(City) (State) (Zip Code)

Phone Number:_____ Medicare HICN:_____

I certify that all of the following statements are true:
I am treating this patient under a comprehensive plan of care for his/her diabetes. This equipment is part of my course of treatment and is "reasonably and medically necessary". This patient needs special shoes (depth or custom-molded) and inserts because of their diabetic condition.

This Patient Has Diabetes Mellitus. (List ICD-10 Codes): _____
(Applicable ICD-10 Range E08.00-E13.90)

This Patient Has One or More of the Following Conditions. (Check all that apply).

- ☐ History of Partial or Complete Foot Amputation
- ☐ Peripheral Neuropathy w/ Evidence of Callus
- ☐ Poor Circulation
- ☐ History of Pre-Ulcerative Callus
- ☐ Foot Deformity (Bunion, Hammertoe, Corns)
- ☐ Previous Ulcer(s)

MD/DO only per medicare requirements no co-signatures

Certifying Physician Information: Name (printed): _____

Signature:_____ Date:___/___/___ NPI:_____
Medicare does not allow co-signatures

Address:_____
(City) (State) (Zip Code)

Phone:_____Fax:_____

Prescription Order for Therapeutic Footwear

Prescribing Physician may be an M.D., D.O. or D.P.M. and may be different from certifying physician

Diagnosis: Diabetes w/ complications Purpose: To protect feet, facilitate ambulation and improve circulation
RX:

_X_ Extra Depth Shoes (A5500), w/ 3 Pair Diabetic Custom Inserts (A5513/A5514)

____ Toe Filler Orthotics (L5000)

MD/DO only per medicare requirements no co-signatures

Prescribing Physician Information:

Signature:_____ Date Signed:_____
Medicare does not allow co-signatures

Name (printed):_____ NPI:_____

This prescription is giving provider authority to dispense prescribed items.

Please send form to: Cornerstone Prosthetics and Orthotics
FOR MEDICARE PATIENTS: FAX THIS PAGE WITH SUPPORTING CHART NOTES TO
1300 44th St SE, Everett, WA 98203 - Phone: 425-339-2559 Fax: 425-339-1583

Form 2 of 2
PLEASE FAX TO: 425-339-1583

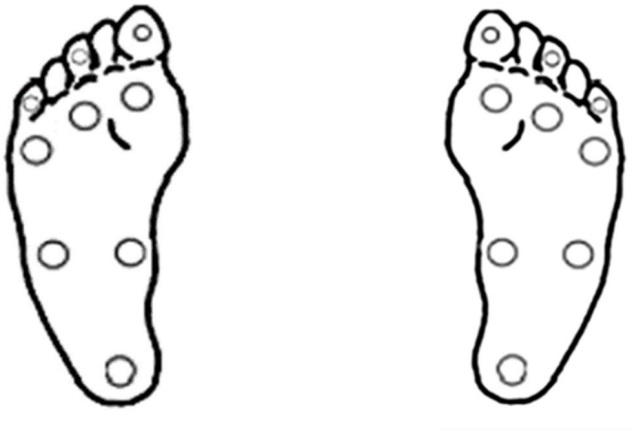
Physician Notes on Qualifying Conditions for Therapeutic Footwear

The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician.

Patient Name: _____ Date of Birth: _____
Physician Name: _____ Date of Exam: _____

Indicate the level of sensation in the circles on the foot diagram.

10-g Semmes-Weinstein 5.07 Monofilament Test
+ = sensation present
- = sensation absent
! = sensation diminished



Left Right

QUALIFYING CONDITIONS:
I have diagnosed this patient with one or more of the following conditions **(check all that may apply and include notes regarding the diagnosis)**:

Physical Exam:

	Left	Right	No
Previous Amputation	☐ 1 2 3 4 5 TM	☐ 1 2 3 4 5 TM	☐
Current Foot Ulcer(s)	☐	☐	☐
History of Foot Ulcer(s)	☐	☐	☐
Toe Deformity (Bunion, etc.)	☐ 1 2 3 4 5	☐ 1 2 3 4 5	☐
Abnormal Foot Shape	☐	☐	☐
Evidence of Callus	☐	☐	☐
History of Pre-Ulcerative Callus	☐	☐	☐
Edema	☐	☐	☐
Blister /Laceration	☐	☐	☐

Vascular Exam:

	Left	Right
Dorsalis Pedis	Y ☐ N ☐	Y ☐ N ☐
Posterior Tibial	Y ☐ N ☐	Y ☐ N ☐
Capillary Refill	0-5 5+	0-5 5+

Vascular findings constitute poor circulation to lower extremities.
YES ☐ NO ☐

Certifying Physician Acknowledgement:
I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. Part of my comprehensive plan of care includes therapeutic footwear.

Certifying Physician Name: (printed): _____

Signature: _____ Date: ___/___/___ NPI: _____
Medicare does not allow co-signatures

MD/DO only per medicare requirements no co-signatures

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