WASHINGTON ORTHOTICS AND PROSTHETICS
PATIENT REGISTRATION FORM

Patient Name: _____
(LAST) (FIRST) (MI)

Date of Birth: _____/_____/_____ SSN: _____ Gender: M _____ F _____

Street Address:_____

City: _____ State: _____Zip: _____

Mailing Address: _____

Home Phone: _____ Cell: _____Work Phone: _____

Employer: _____ Spouse/Parent's Employer: _____

Referring Physician: _____ Primary Physician: _____

Diabetic: YES___ NO ___Diabetic Physician_____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Email address:_____@_____

Allergies: YES___ NO___ If yes, please list: _____

***Are you in a Nursing Facility? YES_____NO_____** If so which one_____

INSURANCE INFORMATION
****PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST****

Is this related to a Work-Related Injury or Automobile Accident? YES/NO If Yes, Please give Date of Injury: ___/___/___

Primary Insurance: _____ ID#: _____

Subscriber: _____ DOB: ____/_____/____ SSN: _____

Secondary Insurance: _____ ID#: _____

Subscriber: _____ DOB: ____/____/_____ SSN: _____

****** TO OUR MEDICARE PATIENTS******
Within the last five (5) years have you received a same or similar item? YES____NO ____

PLEASE READ THE FOLLOWING, SIGN AND DATE BELOW

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. I authorize my insurance benefits to be paid directly to Lizotte P&O Associates, dba Washington Orthotics and Prosthetics/Pacific Prosthetics and Orthotics. I also authorize WAO&P to release to my insurance provider any information required for this claim. I request that payment of authorized Medicare benefits be made either to me or on my behalf to WAO&P for any services furnished to me by WAO&P. I further authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. The patient, if physically and mentally competent, must sign on his own behalf. If he/she cannot sign, a representative payee designated by the Social Security Administration, legally appointed guardian, POA, or responsible party may sign.

_____

PATIENT SIGNATURE **DATE SIGNED**

_____

SIGNATURE OF LEGAL REPRESENTATIVE **DATE SIGNED**

_____

PRINTED NAME AND RELATIONSHIP OF LEGAL REPRESENTATIVE

Patient information form

Please take a moment to fill out this form to the best of your ability. This form is used by our practitioners for informational purposes to improve the outcome of your visit.

Are you diabetic? Yes No

Who referred you to our clinic (your doctor)? _____

What is the primary reason you are here today?
_____

Do you have any physical limitations that we will need to consider? No Yes - Please list:

_____
_____

Do you currently wear special shoes, a brace, or prosthesis? No Yes -Please describe and include where you received your device:
_____
_____
_____

Have you ever worn special shoes, orthotics, a brace, or prosthesis in the past? No Yes

If yes, why do you no longer wear the device?
_____
_____

Do you have any open sores on your feet/residual limbs currently? No Yes

How would you describe your current activity level? Non-ambulatory Low Medium High

Height _____Weight _____Shoe size_____

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **Washington Orthotics and Prosthetics'** *Notice of Privacy Practices.* The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Washington Orthotics and Prosthetics'** health care operations. The *Notice of Privacy Practices* also describes my rights and **Washington Orthotics and Prosthetics'** duties with respect to my protected health information.

Washington Orthotics and Prosthetics reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

I have also received a copy of the Medicare Supplier Standards.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Attention Diabetic Shoe Beneficiaries

The following documentation MUST be provided to Washington Orthotics and Prosthetics prior to your scheduled visit. While we are here to help, it ***is your responsibility*** *to gather information and supply it directly to our clinic.*

1. *Most recent notes from the Certifying Physician -defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is* responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care.

2. *Statement of certifying physician form completed by the Certifying Physician. The Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.)* The certifying physician ***can't be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.***

3. *Prescription for diabetic shoes and inserts from* the Prescribing Physician. The Prescribing physician is the person who actually writes the order for the therapeutic shoe, modifications and inserts. The prescribing physician may be a podiatrist, M.D., D.O., physician assistant, nurse practitioner, or clinical nurse specialist.

Washington Orthotics &Prosthetics

1902 S Cedar St

Tacoma, WA 98405

253-761-9255

253-752-7829 (fax)

Please keep this for your records. We will only need the 3rd page and Recent Chart notes

WASHINGTON ORTHOTICS & PROSTHETICS
Professional Services · Individual Solutions
TACOMA - LAKEWOOD - GIG HARBOR

Therapeutic Shoes for Diabetics – Physician Documentation Requirements

Dear Physician,

Medicare covers therapeutic shoes and inserts for persons with diabetes. This statutory benefit is limited to one pair of shoes and up to 3 pairs of inserts or shoe modifications per calendar year. However, in order for these items to be covered for your patient, the following criteria must be met:

- An M.D. or D.O. (termed the "certifying physician") must be managing the patient's diabetes under a comprehensive plan of care and must certify that the patient needs therapeutic shoes.
- That certifying physician must document that the patient has one or more of the following qualifying conditions:
    - Foot deformity
    - Current or previous foot ulceration
    - Current or previous pre-ulcerative calluses
    - Previous partial amputation of one or both feet or complete amputation of one foot
    - Peripheral neuropathy with evidence of callus formation
    - Poor circulation

According to Medicare national policy, it is not sufficient for a podiatrist, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) to provide that documentation (although they are permitted to sign the order for the shoes and inserts) .The certifying physician must be an M.D. or D.O.

The following documentation is required in order for Medicare to pay for therapeutic shoes and inserts and must be provided by the physician to the supplier, if requested:

1. **A detailed written order.** This can be prepared by the supplier but must be signed and dated by you to indicate agreement.
2. **A copy of an office visit note from your medical records that shows that you are managing the patient's diabetes.** This note should be within 6 months prior to delivery of the shoes and inserts.
3. **Either (a) a copy of an office visit note from your medical records that describes one of the qualifying conditions or (b) an office visit note from another physician (e.g., podiatrist) or from a PA, NP, or CNS that describes one of the qualifying conditions** .If option (b) is used, you must sign, date, and make a note on that document indicating your agreement and send that to the supplier.
   The note documenting the qualifying condition(s) must be more detailed than the general descriptions that are listed above. It must describe (examples not all-inclusive):
    - The specific foot deformity (e.g., bunion, hammer toe, etc.); or
    - The location of a foot ulcer or callus or a history of one these conditions; or
    - The type of foot amputation; or
    - Symptoms, signs, or tests supporting a diagnosis of peripheral neuropathy plus the presence of a callus; or
    - The specifics about poor circulation in the feet – e.g., a diagnosis of venous or arterial insufficiency or symptoms, signs, or test documenting one of these diagnoses .A diagnosis of

hypertension, coronary artery disease, or congestive heart failure or the presence of edema are not by themselves sufficient .

4. **A certification form stating that the coverage criteria described above have been met.** This form will be provided by the supplier but must be completed, signed, and dated by you after the visits described in #2 and 3 .If option 3(b) is used, that visit note must be signed prior to or at the same time as the completion of the certification form. However, this form is not sufficient by itself to show that the coverage criteria have been met, but must be supported by other documents in your medical records – as noted in #2 and 3.

New documentation is required yearly in order for Medicare to pay for replacement shoes and inserts.

Physicians can review the complete Local Coverage Determination and Policy Article titled Therapeutic Shoes for Persons with Diabetes on the Noridian web site at www.noridianmedicare.com/dme. It may also be viewed in the local coverage section of the Medicare Coverage Database at www.cms.hhs.gov/mcd/search.asp.

Suppliers may ask you to provide the medical documentation described above on a routine basis in order to assure that Medicare will pay for these items and that your patient will not be held financially liable. Providing this documentation is in compliance with the HIPPA Privacy Rule. No specific authorization is required from your patient. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the therapeutic shoes and inserts that are needed by your patient.

Sincerely,

Paul J. Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A

Robert D. Hoover, Jr., MD, MPH, FACP Medical Director, DME MAC, Jurisdiction C

Adrian M. Oleck, M.D.
Medical Director, DME MAC, Jurisdiction B

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC, Jurisdiction D

CERTIFICATE OF MEDICAL NECESSITY / STATEMENT OF CERTIFYING PHYSICIAN For Therapeutic Shoes

Please complete the Certificate of Medical Necessity below so that **Washington Orthotics & Prosthetics** may provide therapeutic shoes & inserts. In order to qualify for Medicare, your certification that they meet the conditions listed

below is required along with your Documentation supporting the patient's diabetic conditions.

Please supply most recent chart notes (within the last 6 months)

Patient: _____ **DOB:** _____ **Phone #**_____

This patient has diabetes mellitus: ◯pe ll (E11.9) Typ◯ (E10.9) other: _____

1) This patient has one or more of the following conditions (**check all that apply**):

   - ○ History of partial or complete amputation of the foot. (ICD-10 Code(s) _____)
   - ○ History of previous foot ulceration. (ICD-10 Code(s): _____)
   - ○ History of pre-ulcerative callus. (ICD-10 Code(s): _____)
   - ○ Peripheral neuropathy with evidence of callus formation (ICD-10 Code(s): _____)
   - ○ Foot deformity. (ICD-10 Code(s): _____)
   - ○ Poor circulation. (ICD-10 Code(s): _____)

2) I am treating this patient under a comprehensive plan for care of his/her diabetes.

3) This patient needs special shoes (depth or custom-molded) because of his/her diabetes.

4) This patient needs shoe inserts (heat-molded or custom fabricated) because of his/her diabetes.

Physician Signature (MD or Do): _____ Date: _____

Physician Name: _____ NPI #: _____

Physician Address: _____

_____

Phone Number: _____

Please fax Form & Chart notes to:

Washington Orthotics & Prosthetics
1902 S Cedar St
Tacoma, WA 98405
(253) 761-9255 (phone)
(253) 752-7829 (fax)

Diabetic Shoes Frequently Asked Questions

Does Medicare cover shoes? *Yes Medicare pays 80% for qualifying diabetic shoe beneficiaries. You may be responsible for 20%, approximately $80.00, We can bill a secondary insurance (if applicable).*

What do I need to bring with me for my visit? *Please carefully review the critical **three pieces** of documentation, we can help clarify exactly what we need.*

How often can I get new shoes? *Medicare will cover one pair of shoes and three pair of inserts once per calendar year if needed, for example one pair of shoes and three pair of inserts will be allowed in the year 2013.*

Do I have a choice or selection? *We have carefully chosen quality Medicare approved shoes that we stock in our facility.*

Are they custom-made for my feet? *Most shoes are custom fitted meaning that your feet are measured and shoes are fitted accordingly. However, there are times when custom molded shoes are required*

What do diabetic shoes look like? *We have selected quality Medicare approved shoes that resemble a casual type walking shoe.*

How our diabetic shoes sized? *Diabetic shoes are typically are looser fitting than what you are used to, meaning that the toe box* will have plenty of room to ensure a healthy foot. Your foot will appreciate this extra room!00

Will they be comfortable? Absolutely! Again your new shoes may have more room than you are typically used to but they will allow your foot to move freely in the toe box area to improve foot health and comfort.

What if I want a second pair, will my insurance cover those? *No, Medicare only allows one pair per calendar year. You may purchase a second pair and pay out*-of-pocket the cost is $125.00

What if I want to wear my own shoes from time to time? *We encourage you to wear your new diabetic type shoes most of the time to ensure happy healthy feet. However, a special occasion may require a different shoe from time to time.*