PROVIDER INFORMATION
FOR DIABETIC SHOES AND INSERTS

John's Pharmacy
2001 Independence St., Cape Girardeau, MO 63703
Phone: 573-334-1300 | Fax: 573-334-0493

3 Steps are necessary for your patient to qualify for Diabetic Shoes and Inserts.

Per Medicare Guidelines

STEP 1

Have an in-person visit with the patient to discuss the following:

1. Diabetes management (Must be M.D. of O.D. who is treating the diabetes)
   AND
2. Determine the patient's need for diabetic shoes and inserts.

STEP 2

Complete two (2) forms:

FORM 1 – PRESCRIPTION FOR DIABETIC SHOES AND INSERTS
(May be completed by M.D, D.O., D.P.M., N.P. or P.A.)

FORM 2 – PHYSICIAN'S CERTIFYING STATEMENT
(Must be completed by M.D. or D.O. who is treating the diabetes)

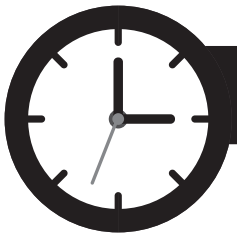
STEP 3

Fax or email the following to John's Pharmacy:

- **FORM 1 – PRESCRIPTION FOR DIABETIC SHOES AND INSERTS**
- **FORM 2 – PHYSICIAN'S CERTIFYING STATEMENT**
- **SIGNED PROGRESS NOTES**
  that document both diabetes management AND the qualifying condition selected on the Physician's Certifying Statement.

JOHN'S PHARMACY FAX: 573-334-0493
OR EMAIL TO: carol@johnsrx.com

If you have questions, please call John's Pharmacy at: 573-334-1300



TIME IS OF THE ESSENCE

The **PHYSICIAN'S CERTIFYING STATEMENT (FORM2)** is only good for **three (3) months** from the date of physician's signature on the form.

The **PROGRESS NOTES** that document diabetes management and the qualifying condition(s) selected on the certifying statement can only be used for up to **six (6) months** from the date of the office visit.

DIABETIC SHOES AND INSERTS

FORM 1

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PRESCRIPTION FOR DIABETIC SHOES AND INSERTS

Name: _____ DOB: _____ Date: _____

Address: _____ Phone: _____

Rx

- ☐ Diabetic Shoes (1 pair of extra depth diabetic shoes) A5500
- ☐ Custom Inserts (3 pair) A5513
- ☐ Prefabricated Inserts (3 pair) A5512

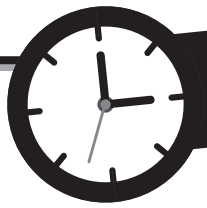
Physician's Name (printed): _____ NPI: _____

Physician's Address: _____

PRESCRIBER SIGNS HERE

Physician's Signature: _____ **Date:** _____

MAY BE COMPLETED BY M.D, D.O., D.P.M., N.P. OR P.A.



EXPIRES SIX (6) MONTHS FROM DATE OF SIGNATURE

DIABETIC SHOES AND INSERTS

FORM 2

John's Pharmacy
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PHYSICIAN'S CERTIFYING STATEMENT

This letter serves as a letter of medical necessity for therapeutic shoes **FOR THREE MONTHS** from John's Pharmacy for the patient named below. Please check all conditions that apply:

Patient Name: _____ DOB: _____

This patient has Diabetes Mellitus. Diagnosis Code: _____
I have seen this patient and examined their feet within the last six months, am treating this patient under a comprehensive plan of care for his/her diabetes and certify that this patient needs extra depth shoes and three pair of custom molded diabetic inserts due to diabetes.

This patient has one or more of the following conditions:

- ☐ A. History of partial or complete amputation of the foot
- ☐ B. History of previous foot ulceration
- ☐ C. History of pre-ulcerative callus
- ☐ D. Peripheral neuropathy with evidence of callus formation
- ☐ E. Foot deformity
- ☐ F. Poor circulation of the feet

Physician's Name (printed): _____ NPI: _____

Physician's Address: _____

PRESCRIBER SIGNS HERE

Physician's Signature: _____ **Date:** _____
MUST BE SIGNED BY M.D. OR D.O.