Diabetic Shoe Documentation

Due to strict insurance guidelines on documentation requirements, we are requesting paperwork for these orders before we schedule patients for their evaluation appointments. This will simplify the process and save time for the patient, the ordering doctor, and the diabetic shoe provider.

To be scheduled for an appointment for diabetic shoes and inserts, a patient must obtain the following documentation from their physicians:

- [ ] Prescription for diabetic shoes from DPM, MD, or DO with diabetic diagnosis code.
- [ ] Diabetic foot exam from the ordering DPM, MD, or DO.
- [ ] Clinical notes from an office visit with the ordering DPM, MD, or DO that discuss the need for diabetic shoes.
- [ ] The attached "Statement of Certifying Physician" from the MD or DO that treats your diabetes. This must be a MD or DO, it cannot be a DPM, PA, CRNP, or APN.

The MedEast Process

Patient Gathers Documentation

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Patient submits documentation to get scheduled for evaluation appointment

Documentation can be emailed to centralintake@medeastortho.com or faxed to (267)299-9001
At the evaluation, the clinician will measure the foot and discuss shoe and insert options.

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MedEast Sends SWO to ordering doctor and receives it back signed

The SWO is the Standard Written Order. This needs to be signed by the ordering doctor to ensure the proper items are being distributed and returned to MedEast.

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MedEast will apply for authorization, if required, and calculate patient's OOP cost

Authorization needs to be approved from the insurance company and the patient needs to approve the OOP cost.

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Shoes will be ordered and patient will be scheduled once the shoes arrive in office

MedEast Post-Op & Surgical
3001 Irwin Road, E
Mt. Laurel, NJ 08054
Tel: (856) 829-2030
Fax: (267) 299-9001

Statement of Certifying Physician and Prescription

Patient Information		
Patient Name	Patient ID	Patient DOB
Device Type	Insurance	Date

The physician listed below certifies that all the following statements are true:
(Physician must be an MD or DO)

1. **This patient has diabetes mellitus.**

2. **This patient has the following conditions (*please 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. **This patient has a diabetic diagnosis of (**ICD 10 code**)** _____

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

☐ **This patient needs special shoes (depth or custom-molded) inserts and/or other custom orthotics because of his/her diabetes.**

_____

Physician Name (must be MD or DO)	Physician NPI
Physician Address	

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

_____ _____

Physician Signature ***Date***

Patient Demographics

This form needs to be completed in it's entirety

Patients will be responsible for any cost incurred due to incorrect or incomplete information

Patient Information

Patient Name (First Middle Last): _____

Date of Birth: _____ Email Address: _____

Cell Phone Number: _____

Home Phone Number: _____

Address (Street, City, State, Zip): _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Insurance Information

Full Insurance Company Name and ID# REQUIRED

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Prescription Information

Type of Prescription: _____

Referring Physician: _____ Phone #: _____

Primary Physician: _____ Phone #: _____

Signature: _____ Date: _____

Name of Representative: _____

Relationship to Patient: _____

I confirm that the above demographic and insurance information is correct. I agree that if there are or will be any changes to this demographic information or insurance coverage at any point prior to delivery, I will immediately notify MedEast Post Op & Surgical, Inc.

I understand that failure to notify MedEast of changes may result in the patient being billed. MedEast will take all steps to check insurance benefits and obtain authorization, however authorization is not a guarantee of coverage. I understand that the patient is ultimately responsible for all financial obligations related to the above product, including deductibles, co-insurance and any other patient responsibilities indicated by the insurance carrier.

3001 Irwin Road, Suite E
Mount Laurel, NJ 08054
Ph: (856) 829-2030
Fax: (267) 299-9001

PATIENT AGREEMENT

Patient Right to Choose: MedEast Post-Op & Surgical, Inc. is an independent company that works with this facility to provide a variety of durable medical equipment orthotics, prosthetics, and supplies (DMEPOS) that you may require. You have the right to use a DMEPOS supplier of your choice for the items being prescribed. Should you choose to use an alternate DMEPOS supplier, a list of local companies is listed on the back of the patient copy of this form. By signing this agreement, you acknowledge your choice to have MedEast Post-Op & Surgical, Inc. service your DMEPOS needs.

Assignment of Benefits: As a courtesy to the patients and their families, DME Supplier* does submit a claim to many third-party payers. I request that payment of authorized Medicare or private benefits be made to DME Supplier for any covered services furnished to me by DME Supplier. If my insurance carrier pays me directly, I agree to forward all funds to DME Supplier within ten (10) working days. I agree that I am responsible for immediately notifying DME Supplier of any changes of my insurance carrier. I agree that I am responsible for paying all non-covered or unpaid amounts unless otherwise provided by law, regulation or DME Supplier contractual relationships. I agree to be responsible for the full amount of the charges from the date of delivery which my third-party payer does not pay for in a timely manner, or if I fail to provide within ten (10) days the information necessary to submit the claim for payment.

Disclosure of Information: I understand that my medical records and billing information are made and retained by DME Supplier and are accessible to DME Supplier personnel who may use and disclose medical information for DME Supplier operations and functions and to any other health care personnel involved in my continuum of care for this product.

Release of Records: I authorize DME Supplier to release to any governmental healthcare program and its agents, or to any private insurance company or its agents any information needed to determine my benefits or the benefits payable for DME Supplier. I hereby authorize my ordering physician to release all medical records pertaining to my healthcare information to DME Supplier. I understand further that the information, authorized for release may include records which contain the diagnosis of communicable or venereal disease.

Acknowledgment of Notice of Privacy Practices: A complete description of how my medical information will be used and disclosed by DME Supplier has been given to me in DME Supplier HIPAA compliant NOTICE OF PRIVACY PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this Consent Form. If I have questions, I know to contact the Privacy Officer whose information is provided to me in the Notice of Privacy Practices.

Acknowledgement of Product: I acknowledge and understand the item(s) being provided by MedEast Post Op & Surgical Inc. are being specifically ordered and/or custom fabricated for the patient. I acknowledge that the product has been discussed with me and I agree to have MedEast Post Op & Surgical, Inc. order / fabricate the item(s). I understand that once ordered, the product cannot be cancelled, refused or returned (with the exception of items covered under warranty)

Authority to contact: I agree to receive information from MedEast by text, voicemail and email.

No_____ Yes _____ Mobile phone#: _____ Home phone #: _____

No _____Yes _____ Email address: _____

I HAVE READ AND AGREE TO THE STATEMENTS AND CONDITIONS STATED HEREIN

Patient Name: _____

Signature: _____ Date: _____

Name (if other than patient): _____Relationship: _____