1932 Broadway
Everett, WA 98201
Phone: 425-303-0108
Fax: 425-303-2539

7501 Custer Road West
Lakewood, WA 98499
Phone: 253-473-4311
Fax: 253-473-4408

Services We Provide

- Diabetic Footwear
- Orthopedic Footwear
- Custom Foot Orthotics
- Shoe Lifts for Leg Length Issues
- Shoe Repair
- Shoe Resole
- Compression Stockings
- Diabetic Socks

Many Insurances Accepted

Call Us for More Information

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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.

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 Patients 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 above.

Prescription for Diabetic Shoes and/or Orthotic Inserts

Patient Name:____

Date of Birth:________________________ Phone:___________________

ICD-10 Diagnosis:____

RX: **A5500** One Pair of Diabetic Extra Depth Shoes

A5513 Up to Three Pair of Custom Diabetic Multi Density Inserts from Direct Molds

A5514 Up to Three Pair of Custom Diabetic Multi Density Inserts from CadCam System

Additional Instructions (shoe modifications, etc.):

RX Start Date (REQUIRED) :________________Length of Need:_____________

Prognosis ☐ Good ☐ Fair ☐ Poor

Physician's Signature:_______________________________Date:___________

Physician's Name (Printed):______________________________________

Practice Address:____

____

Physician's Phone:_____________________ Fax:____________________

Physician's NPI:____

FOR MEDICARE PATIENTS:
FAX THIS PAGE WITH SUPPORTING CHART NOTES TO
425-303-2539 (EVERETT) OR 253-473-4408 (LAKEWOOD)

Althea's
FOOTWEAR SOLUTIONS

Certificate of Medical Necessity for Therapeutic Shoes

Patient Name:____

Date of Birth:________________________ Phone:___________________

I certify that the following statements are true:

1. The patient listed above has Diabetes Mellitus
   ☐ Type I ☐ Type II ☐ Not Diabetic
2. ICD-10 Diagnosis Code: _____________________________________
3. 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**):
   - ☐ History of a previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy WITH evidence of callus formation (must have both)
   - ☐ Foot deformity
   - ☐ Poor foot circulation
   - ☐ History of partial or complete amputation of the foot or toes

The following qualifications must be met :

- I am treating this patient under a comprehensive plan of care for Diabetes Mellitus.

- The patient needs extra depth shoes with multiple density inserts because of diabetes.

- I certify that the conditions indicated above have been checked in the last six months and are detailed in the physician's notes.

MD/DO Signature:____________________________ Date:_____________

MD/DO Printed Name: ____

Office Phone:_______________________ Fax:______________________

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