Statement of Medical Necessity

(To be completed **and** signed by the physician who manages your diabetic condition).

Patient's Name_____Date_____

Patient's Address _____Zip_____

Patient's Phone #_____Date of Birth_____

Patient Diagnosis

Is the patient Diabetic: Yes_____ No_____

Related Diagnosis_____

Diabetic Foot Conditions

Amputation (Part/Complete): Yes_____ No_____

istory of Foot ulceration: Yes_____ No_____

Pre-ulcerative Callouses: Yes_____ No_____

Peripheral Neuropathy/ Callouses : Yes_____ No_____

Foot Deformity : Yes_____ No_____

Poor circulation/diminished pulses: Yes_____ No_____

Comprehensive Care Plan

Is patient under a comprehensive Plan of care for their diabetes : Yes_____ No_____

Does this patient need diabetic shoes (Extra-depth or custom molded) Due to their diabetes: Yes_____ No_____

_____

Managing physician, printed

_____

Managing physician, Signature

Phone #_____ NPI#_____

Medicare will not accept typed or stamped signature

Corrigan Podiatry Group
Dr. Tom Corrigan
(440) 871-3400

How can I get a pair of diabetic shoes?

Medicare Part B will cover 80% of the cost of the following once every calendar year.
*One pair of Extra Depth shoes with three pairs of heat moldable soft inserts

OR
* One pair of custom molded shoes with three molded inserts

If you have a secondary they ***should*** cover the other 20%.

Who qualifies for these shoes?

Any medicare patient with documentation from the physician who is managing the systemic diabetic condition stating that the patient is being treated under a comprehensive plan of care for diabetes and that the patient has one or more of the following conditions:

Poor Circulation / Cold Feet
Callouses with Peripheral Neuropathy
Foot Deformity (hammertoes/bunions/corns)
History of previous ulcers on the foot
Previous amputation of foot or part of foot

Simply ask our doctor or staff if you feel you or someone you know would benefit from professionally fitted diabetic shoes and inserts

Prescription for diabetic shoegear
(To be completed and signed by Dr. Tom Corrigan who will order/fit your diabetic shoes)

Patient's Name_____Date_____

Patient's Address _____Zip_____

Patient's Phone #_____Date of Birth_____

Dx_____Prognosis_____

Years pt has been Diabetic_____

Shoe type: Extra depth or Custom molded

Inserts: Heat moldable or Custom Scanned

Modifications:_____N/A_____

Shoe Size_____Male or Female_____

Shoe Width_____ M_____ Wide_____ Extra Wide_____

Catalogue number _____

Special Requests_____

Dr. Tom Corrigan

Printed

Thomas A. Corrigan, DPM / Signature_____

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NPI#: 1952484958