HILL COUNTRY
Orthotics & Prosthetics

Diabetic Shoe Documentation Requirements

We must have **ALL of the documentation** below on file prior to scheduling an appointment for your patient. To ensure that they receive timely and efficient care, please provide the following:

- ☐ **Statement of Certifying Physician** prepared by the MD or DO* managing the patient's diabetic condition and dated within 3 months of final shoe delivery.
- ☐ **Detailed Chart Notes** prepared by the same Certifying Physician*. Must be identical to Statement of Certifying Physician and dated within 6 months of final shoe delivery.
- ☐ **Prescription** dated within 6 months of final shoe delivery.
- ☐ **Patient Demographics.**
- ☐ **Prior Authorization (Humana Gold Patients Only).**
  Must contain prescribed CPT Codes.

Verify that all boxes are checked prior to faxing order. We cannot see patients until all documentation requirements have been met.

*We cannot accept Statements prepared by a PA, FNP, or DPM unless prepared as part of a comprehensive treatment plan created by the Certifying Physician. For us to accept one of these statements, a copy of the comprehensive treatment plan must be sent to Hill Country Orthotics & Prosthetics prior to faxing order.

Central Intake Fax: (210) 694-4581 | Central Intake Phone: (210) 614-8777

Accepted Insurance:

Humana Gold
Tricare
BC/BS PPO

Medicare & Medicaid
WellMed
- Preferred Provider

Please contact our office if you have any questions about insurance.

Locations:

San Antonio, Medical Center
4242 Medical Dr.
Building 2, Suite 2100
San Antonio, TX 78229

San Antonio, South Side
6631 S. Zarzamora St.
San Antonio, TX 78211

Austin
111 W. Anderson Ln., Suite A-102
Austin, TX 78750

Corpus Christi
226 S. Enterprize Pkwy., Suite 110
Corpus Christi, TX 78405

Harlingen
1821 Hale Ave., Suite 17
Harlingen, TX 78550

McAllen
600 N. McColl, Suite 602
McAllen, TX 78501

El Paso
1326 E. Yandell Dr.
El Paso, TX 79902

HILL COUNTRY
Orthotics & Prosthetics

Prescription for Diabetic Shoes & Inserts

Fax Orders to: (210) 694-4581

Patient Name: _____ **Date:** _____

ICD 10: _____ **Diagnosis:** _____ **DOB:** _____

Length of Need (Number of Months or Lifetime)**:** _____ **Start Date:** _____

Items Needed:

- ☐ Diabetic Shoes A5500 with 3 pairs Diabetic Inserts, heat molded A5512
- ☐ Diabetic Shoes A5500 with 3 pairs Diabetic Inserts, custom A5513/A5514
- ☐ Diabetic Shoes A5500 with:
  - ☐ 3 Diabetic Inserts, custom A5513/A5514 (select side)
    - ☐ Right
    - ☐ Left
  - ☐ 1 Toe Filler L5500 (select side)
    - ☐ Right
    - ☐ Left
- ☐ Diabetic Shoes A5500 with L5500 Toe Filler Bilateral

☐ Additional Items* (To prescribe any additional items not listed above, please fully describe items below (include Quantity and Right/Left/Bilateral)

*Other services include but are not limited to upper and lower extremity prosthetics, custom/off-the-shelf upper and lower extremity orthotics, custom and prefabricated lumbar orthotics.

Letter of Medical Necessity:

The above patient has been under my care and is in need of the prescribed orthopedic product. This product was prescribed to aid and/or accelerate the rehabilitation process and is deemed medically necessary.

Physician Name: _____ **NPI#:** _____
(Please Print)

Physician Signature: _____ **Date:** _____
(Medicare Requires Hand Signature and Date)

Central Intake Phone: (210) 614-8777

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

HIC #: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
   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
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician signature: _____

Date Signed:_____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

_____

Physician address:

_____

_____

_____

Physician NPI: _____