Dear Patient,

The attached form TSS (Therapeutic Shoe Statement) is a requirement by your insurance company for us to bill diabetic shoes and inserts. Your treating diabetic doctor (MD/DO) **(who diagnosed your diabetes, prescribes your medication for your diabetes and manages your treatment plan for your diabetes.)** MUST sign, date, and check off one of the required conditions on the form. ANY information not filled out will delay the ordering process.

In addition to the completed form, we also need **medical records (notes) from the treating MD/DO PERTAINING** to the treatment of your diabetes with in the last 120 days, if you have not been seen by your treating diabetic doctor with in the last 120 days for the treatment of your diabetes, **please contact your PCP or Endocrinologist** to make an appointment.

Once this form is completed with the notes this can be faxed to the O&P Department at 800-933-1356. If you have any questions, please call Elizur O&P department at 844-628-8813.

Please note this form is to be completed by your TREATING Diabetic Doctor NOT the Podiatrist (DPM) or referring doctor that sent the prescription to us. Any questions on this form or who needs to complete it please call our office.

9800A McKnight Road • Pittsburgh, PA 15237
Phone:: 1.844.628.8813 • Fax:: 1.800.933.1356 • www.elizur.com

CERTIFICATE OF MEDICAL NECESSITY

Therapeutic Footwear for Individuals with **Diabetes**

THIS IS NOT A PRESCRIPTION

Identifying Information

Patient Name ______________________________

Date of Birth ______________________________

Practice Name ______________________________

Practice Address ______________________________

Practice Fax ______________________________

Certification

MARK ALL ITEMS THAT APPLY

- ☐ This individual has diabetes mellitus.
- ☐ One or more of the following conditions of coverage are met.
  - ☐ In either foot, the individual has a history of:
    - ☐ Foot ulceration
    - ☐ Pre-ulcerative calluses
    - ☐ Peripheral neuropathy with evidence of callus formation
    - ☐ Foot deformity
    - ☐ Poor circulation
  - ☐ An entire foot has been amputated.
  - ☐ Part of either foot has been amputated.
- ☐ This individual is being treated for diabetes under a comprehensive plan of care by the provider
- ☐ Therapeutic footwear is medically necessary for this individual because of diabetes.
- ☐ The **attached chart notes** include all relevant information from this individual's medical record. ***(from at least the last 90 days)***

Attestation*

COMPLETED BY A MD OR DO

- ☐ I hereby attest that the certification information above is true, correct, and complete.

Provider Name ***(print)*** ______________________________

Date Signed ______________ NPI ______________

Provider Signature ______________________________

Help your patient have their **diabetic shoes** get covered.

As the physician managing their diabetes, your patient's insurance requires a certificate of medical necessity in order to cover their therapeutic shoes and/or inserts prescription.

* The Social Security Act §1861(s)(12) requires that a doctor of medicine (MD) or doctor of osteopathy (DO) certify that the beneficiary receiving therapeutic shoes and inserts is under a comprehensive plan of care for their diabetes.

Attach Chart Notes and Fax to

Fax 800-933-1356

Phone 844-628-8813

REVIEWED/UPDATED: 07/2024