Dear Valued Patient,

Your doctor has provided Elizur Corporation with a prescription (included) to provide you with Diabetic Shoes and/or inserts. **Please thoroughly read through the instructions outlined within this packet so we can provide you with the prescribed products.**

Patients are eligible to receive Diabetic shoes and inserts one time every year (please note, the quantity of these items a patient is eligible to receive can vary from payer to payer). If you would like your shoes and inserts to be billed to your insurance company, additional documentation **must** be obtained from your treating diabetic physician to support the medical necessity of the shoes and inserts. **The following pages should be taken to your treating diabetic physician's office and will detail all the necessary documentation requirements.**

As soon as we receive the required documentation, our team will review the documents. If they meet insurance requirements our scheduling team will call you to set up your evaluation appointment. If the required documentation is not obtained in 30 days from receiving your order, our team will archive the order until we have the necessary documents. Please call the department at 844-628-8813 to check on the status of your documents.

ēlizur offers OrthoFeet diabetic footwear with personalized fitting guidance from our team. Please review the OrthoFeet catalog to explore available styles and note your preferences for your evaluation. Our team will help confirm appropriate footwear, sizing, and fit based on your prescribed needs. Styles, colors, sizes, and widths vary by model and availability.

Sincerely,

Elizur Corporation
(p) 844-628-8813
(f) 800-933-1356

Dear Patient,
The requested below information is a requirement of your insurance provider. Your insurance provider requires that we collect specific documentation from you and your providers to support medical necessity for therapeutic shoes and inserts. **Please take this packet to your appointment and have your Physician complete all required paperwork:**

o **Statement of Certifying Physician for Therapeutic Shoes**
o **Prescription/Standard Written Order**
o **Office Visit Notes** from prescribing provider and physician that treats your diabetes. These evaluations must be within 6 months prior to receiving your shoes and/or inserts. The Statement of Certifying Physician form must be completed by the physician that treats your diabetes.

Your doctor may fax the required documentation directly to Elizur Corporation at 800-933-1356 or you may bring it in. Once we receive these documents, we will review them and if they meet insurance requirements, we will call you to schedule your evaluation/fitting appointment. **If you have any questions regarding your therapeutic shoe needs, please contact Elizur Corporation P&O Department at 844-628-8813.**

_____ INSTRUCTIONS TO TAKE TO YOUR PROVIDER_____

Dear Physician,
Please assist us in providing our mutual patient with diabetic shoes and inserts. Medicare/Insurance states that they need the following documentation from the certifying physician:

☐ **Prescription/Standard Written Order**

- The ordering provider can be doctor, podiatrist, nurse practitioner, physician assistant or clinical nurse specialist.
- The Standard Written Order must be completed by the prescribing provider.

☐**Clinical Evaluation/Notes**

- A copy of an office visit note, from the patient's medical record, that shows management of the patient's diabetes. This office visit **must occur within 6 months prior to delivery** of the shoes and inserts.
- A copy of an office visit note, from the patient's medical record, that **must** document a foot exam with a qualifying foot condition. The evaluation **must be within 6 months** prior to the patient receiving shoes and/or inserts. This interaction can be between:
  - **(a)** The patient and the certifying physician *or*
  - **(b)** The patient and another qualified practitioner (such as a podiatrist, NP, PA, or certified nurse specialist [CNS]).
    - ***If option (b) is used, then the certifying physician must sign, date, and make a note on that document indicating agreement and send that to the supplier.***

☐ **Statement of Certifying Physician for Therapeutic Shoes**

- This form must be completed, signed, and dated by the certifying physician on the same day or after the date of the office visits described above within 3 months prior to delivery. **This physician must be an MD or DO.**
- This document certifies the patient's diagnosis of diabetes, and that the patient has a qualifying condition necessitating treatment with therapeutic shoes as part of their comprehensive plan.

***If the Statement or Diabetic Management Notes are authored/signed/completed by NP or PA, the supervising MD/DO the NP or PA works incident to must review and verify (sign/date) acknowledging agreement with the NP or PA.*

***Providing this documentation to the supplier is in compliance with the Health Insurance Portability and Accountability Act Privacy Rule. No specific authorization is required from your patient*

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

elizur
ORTHOTICS & PROSTHETICS

Standard Written Order for Therapeutic Shoes for Diabetes
All fields are required by payer to be completed by the certifying physician

Patient name**:** _____ DOB**:** _____

Date of Order**:** _____

Diagnosis (ICD 10)**:** _____
There must be an E code for shoes and inserts and a Z code for toe fillers

Shoes

QTY: _____

- Extra Depth
- Custom Molded

Inserts

Pairs (please circle) 1 2 3

- Toe Filler Left Right
- Prefabricated Left Right
- Custom Fabricated Left Right
- Other_____

Additional Instructions:

_____

_____

_____

Ordering Physician Information

Name (Printed): _____
Address:_____
City:_____ State: _____ Zip:_____
NPI:_____
Signature: _____**Date:**_____

please fax ALL completed forms **and notes** to Elizur Corporation P&O Department
800-933-1356

PATIENT CHECK LIST

- ☐ **Office notes from the most recent diabetic maintenance appointment that show continued diabetic treatment AND a diabetic foot exam**
  - *Please note you may be required to schedule an appointment with your diabetic MD (PCP or Endo) as these office notes are required to be within **6 months** at the time your shoes and inserts are delivered to you.*
  - *If the foot exam was completed by a different provider (Podiatrist, PA, CRNP etc.) those note **must** be taken to your treating diabetic physician and they **must** sign and date in agreeance with the findings.*

- ☐ **Signed Certificate of medical necessity**
  - *Please verify the certificate of medical necessity is signed by an MD or DO. If it is signed by a PA, CRNP etc. it is considered **invalid.***
  - *This form must be signed **at the same time** or **after** your diabetic maintenance appointment and must be withing **3 months** at the time you receive you shoes and inserts.*
  - *If the date on this form is <u>before</u> the date of your diabetic maintenance appointment you will be required to obtain a new signed form.*

- ☐ **Signed and Completed Standard Written Order**

Once you or your physician have obtained all of the above documentation, you may have it faxed to our P&O Department at: 800-933-1356.

Once our diabetic shoe team receives this documentation, they will review it to make sure it meets insurance requirements. If it does <u>not,</u> we will call to inform you, and you must obtain the corrected information. If the documentation meets insurance requirements, our scheduling team will call to schedule your evaluation appointment. If our department receives nothing within 30 days of receiving the prescription OR HAS NOT RECEIVED COMPLETE AND VALID DOCUMENTATION we will archive the order until we receive the required documents. Please call our department at 844-628-8813 to check on the status of your documents.

*****please note you MAY be required to obtain updated documentation prior to receiving your products if the office notes/certificate of medical necessity become invalid during your order*****