Yanke Bionics, Inc.
Statement of Certifying Physician
for Therapeutic Shoes

Patient Name: _____
Medicare Number: _____

I certify that all of the following statements are true and that I have performed an in-patient evaluation of the patient within the last six months.

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)because of his/her diabetes.**

MD/DO Signature:_____
Date: _____ **UPIN Number:**_____

MD/DO Name (Printed): _____
Address : _____
Phone Number ( ) :_____
Last In-Patient Visit Re: Diabetic Management _____

***** MUST be Signed by a MD/DO, No Stamped Signatures*****

PLEASE ALSO FAX CLINICAL /OFFICE NOTES SUPPORTING THIS STATEMENT

Please Fax To:

AKRON
303 W Exchange St
Akron, OH 44302
800-862-6019
Fax: 330-762-4110

BROOK PARK
15900 Snow Rd Ste 400
Brook Park, OH 44142
440-233-4314
Fax: 440-233-7526

CAMBRIDGE
10187 Cadiz Rd
Cambridge, OH 43725
740-439-2233
Fax: 740-439-2555

CANTON
4604 W Tuscarawas
Canton, OH 44708
330-479-9662
Fax: 330-479-9716

KENT
1444 E.Main St Ste C
Kent, OH 44240
330-673-1904
Fax: 330-968-6596

LORAIN
6100 S Broadway Ste 104
Lorain, OH 44053
440-233-4314
Fax:440-233-7526

MANSFIELD
265 Sterkel Blvd, Ste 101
Mansfield, OH 44907
419-529-2300
Fax: 419-529-3800

MONTROSE
3975 Embassy Pkwy
Akron, OH 44333
330-668-4070
Fax: 330-668-4072

NEW PHILADELPHIA
2300 E High St
New Philadelphia, OH 44663
330-339-7900
Fax: 330-339-7955

NORTHFIELD
61 W. Aurora Rd. Ste B
Northfield, OH 44067
330-467-0001
Fax: 216-751-6248

PARMA
2119 Brookpark Rd
Parma, OH 44134
216-741-4112
Fax: 216-741-5003

WOOSTER
2922 Cleveland Rd
Wooster, OH 44691
330-345-6657
Fax: 330-601-0777

YANKE BIONICS

Prosthetic & Orthotic Patient Care

Diabetic Therapeutic Shoe Program

Prescription / Letter of Medical Necessity

Patient Name:
Patient Address:
City, State, Zip:
Date of Order: **Right ____ Left ____ Bilateral ____**

Off-the-Shelf Diabetic Shoes

___ A5500 Diabetic Shoe, Off-the-Shelf, Depth-Inlay, per Shoe. Pair ____

___ A5513 Diabetic Custom Molded Multi-Density Inserts, each Each ____

___ A5514 Diabetic Custom Insert, Direct Milled, each Each ____

___ OTHER: _____ Each ____

Or

Custom Molded Diabetic Shoes

___ A5501 Diabetic Shoe, Custom Molded Shoe from Cast of Patient's Foot Pair ____

___ A5513 Diabetic Custom Molded Multi-Density Inserts, each Each ____

___ A5514 Diabetic Custom Insert, Direct Milled, each Each ____

___ OTHER: _____ Each ____

Diagnosis: _____ **ICD 9/10 Code:** _____

Diagnosis: _____ **ICD 9/10 Code:** _____

Medical Necessity: _____

_____

Physician Signature: _____ **Date:** _____

Print Physician's Name: _____ **NPI #:** _____

Physician Address: _____ **Phone:** _____