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

Dear **Date:**

Thank you for entrusting Yanke Bionics with your Diabetic footwear. Before we can put your Diabetic shoes and/or Diabetic Foot Orthotics into production, we need the following information from your Referring physician (the physician who wrote the prescription for the services) and your Diabetic physician (the physician who manages your diabetes).

We have put the following information/packet together to assist in providing you with the information required by Medicare for your diabetic shoes and inserts. Once we receive the required information from your physicians, we will promptly schedule you for your services.

Medicare/CMS policy requires us to have the following documentation on file prior to providing these services.

1. **CERTIFYING PHYSICIAN STATEMENT – (Diabetic Physician) – See Attached**

- Certifying Physician is an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathy)
- Signed and dated Certifying Physician Statement (physician managing the beneficiary's systematic diabetes condition) that specifies the beneficiary meets the criteria listed below:
    - Has diabetes (ICD-9 diagnosis codes 249.00 – 250.93)
    - Has at least one of the following conditions:
        - a) Previous amputation of the other foot, or part of either foot, or
        - b) History of previous foot ulceration of either foot, or
        - c) History of pre-ulcerative calluses of either foot, or
        - d) Peripheral neuropathy with evidence of callus formation of either foot, or
        - e) Foot deformity of either foot, or
        - f) Poor circulation in either foot.

- Is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes.
- Signature on the Certifying Physician Statements meets CMS Signature Requirements
  http://www.cgsmedicare.com/jc/pubs/news/2010/0410/cope12069.html

2. CERTIFYING PHYSICIAN MEDICAL RECORDS / OFFICE NOTES REQUIRED – (Diabetic Physician)

- Clinical evaluation documenting the management of the patient's diabetes.
  - Evaluation was performed by the Certifying Physician
  - Visit occurred within 6 months prior to delivery, and
  - Signature meets CMS Signature Requirements
    http://www.cgsmedicare.com/jc/pubs/news/2010/0410/cope12069.html
- Clinical evaluation documenting that the beneficiary met one or more of criteria as listed above:
  - Evaluation was either personally performed by the certifying physician OR the certifying physician obtained documentation from another clinician, reviewed the information and indicated agreement with the information by initialing and dating the record;
  - Evaluation was performed and/or reviewed by the Certifying Physician prior to completion of the Statement of Certifying Physician;
  - Visit to document the qualifying foot condition occurred within 6 months prior to delivery; and
  - Signature meets CMS Signature Requirements
    http://www.cgsmedicare.com/jc/pubs/news/2010/0410/cope12069.html

Reminders – Certifying Physician

The Statement of Certifying Physician form is NOT sufficient to meet the Medical Necessity requirements. You must also include your Medical Records. The certifying physician must be an M.D. or D.O. and may not be podiatrist, physician assistance, nurse practitioner, or clinical nurse specialist. A new Certification Statement is required for a shoe, insert or modification provided more than one year from the most recent Certification Statement on file.

3. PRESCRIBING PHYSICIAN PRESCRIPTION / LMN - (Referring Physician) – See Attached

If the Diabetic Physician is also the Prescribing Physician, the enclosed Detailed Prescription / Letter of Medical Necessity will also need to be completed for the services. Please be sure to fill out all sections including the medical necessity. If the physician who prescribed the services, is not managing the patient's diabetic condition, then please complete the prescription.

CHECKLIST

1. CERTIFIYING PHYSICIAN STATEMENT _____
2. CERTIFYING PHYSICIAN MEDICAL RECORDS _____
3. PRESCRIBING (REFERRING) PHYSICIAIN RX _____

We hope that you find this information helpful in providing the required documentation necessary for Yanke Bionics to bill the insurance company for the services. We appreciate your cooperation in this matter. If you have any questions or concerns, please do not hesitate to contact our office.

Sincerely,

Yanke Bionics, Inc.

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:

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Fax: 216-741-5003

WOOSTER
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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:** _____