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, 0H 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

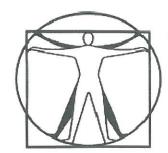
NORTHFIELD 61 W. Aurora Rd. Ste B Northfield, OH 44067 330-467-0001 Fax: 216-751-6248

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:

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

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

CERTIFYING PHYSICIAN STATEMENT - Please Fax (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)
 - o 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

CERTIFYING PHYSICIAN MEDICAL RECORDS / OFFICE NOTES REQUIRED – Please Fax

- 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

The information contained in this communication is intended by Yanke Bionics, Inc. for the use of the named individual or entity to which it is directed and may contain private or confidential information. It is not intended for transmission to, or receipt by, anyone other than the named addressee (or a person authorized to deliver it to the named addressee). It should not be copied or forwarded to any unauthorized persons. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address.

- 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.ht
 ml

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.

PRESCRIBING PHYSICIAN PRESCRIPTION / LMN - Please Fax (See Attached)

If you are also the Prescribing Physician, please complete the enclosed Detailed Prescription / Letter of Medical Necessity for services. Please be sure to fill out all sections including the medical necessity.

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

Please return the required documentation to Fax:	_
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:
MD/DO Signature: Date: UPIN Number:
MD/DO Name (Printed):
Address:
Phone Number ():

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

Last In-Patient Visit Re: Diabetic Management ____

PLEASE ALSO FAX CLINICAL/OFFICE NOTES SUPPORTING THIS STATEMENT

Please Fax To:

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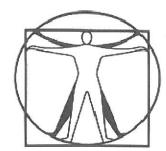
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YANKE BIONICS

Prosthetic & Orthotic Patient Care

Diabetic Therapeutic Shoe Program

Prescription / Letter of Medical Necessity

Patient Name:			
Patient Address:			
City, State, Zip:			
Date of Order: Rig	<u> </u>	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	ı	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	ı	Each	_
A5514 Diabetic Custom Insert, Direct Milled, each		Each	=1
OTHER:	-	Each	_
Diagnosis:	ICD 9/10	Code:	
Diagnosis:	ICD 9/10	Code:	
Medical Necessity:			
Physician Signature:	D	ate:	
Print Physician's Name:			
Physician Address: Phone:			

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