**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:**

**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)
    - 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

- 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.

**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:**_____
**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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# 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:** _____