STATEMENT OF CERTIFYING PHYSICIAN AND PRESCRIPTION FOR THERAPEUTIC SHOES

PATIENT NAME: _____ DOB: _____ SEX:_____

ADDRESS: _____SSN: _____MARITAL STATUS: _____

CITY, STATE, ZIP: _____MEDICARE #: _____

PHONE #: _____OTHER INS #:_____

PRIMARY DIAGNOSIS: ☐ E11.9 ☐ E10.9 ☐ OTHER E11._____

SECONDARY DIAGNOSIS: THIS PATIENT HAS ONE OR MORE CONDITIONS: (circle all that apply)

☐ L84 HISTORY OR PRE-ULCERATIVE CALLOUS

☐ L85.1 KERATODERMA ACQUIRED

☐ Z89._____ HISTORY OF PARTIAL OR COMPLETE AMPUTATION

.429 OTHER TOE .419 HALLUX .439 FOOT .519 BELOW KNEE .619 ABOVE KNEE

☐ S98._____ AMPUTATION OF THE FOOT, UNILATERAL

☐ I87.2 POOR CIRCULATION OF LOWER EXTREMITY

☐ M21.969 FOOT DEFORMITY ☐ M20.10 BUNION ☐ M20.40 HAMMERTOE

☐ L97._____ HISTORY OF PREVIOUS FOOT ULCERATION ☐ OTHER L97.5_____

DATE OF LAST APPOINTMENT IN WHICH DIABETES MANAGEMENT ADDRESSED ____/____/____

☐ **PHYSICIAN TO SEE PATIENT FIRST** ☐ **PATIENT HAS NO DIAGNOSIS LISTED ABOVE**

PRESCRIPTION:

_____DEPTH INLAY SHOE (EACH)	A5500 KX x	2 (1 PAIR)		
_____EXTERNAL HEAT MOLDED MULTIPLE DENSITY INSERTS				
	A5512 KX x	6 (3 PAIR)	4 (2 PAIR)	2 (1 PAIR)
_____CUSTOM MOLDED MULTIPLE DENSITY INSERTS				
	A5513 KX x	6 (3 PAIR)	4 (2 PAIR)	2 (1 PAIR)

EXTERNAL MODIFICATIONS _____

I am treating this patient under a comprehensive plan of care for his/her diabetes and special shoes (depth or custom molded) and/or inserts (including external modifications to shoes) are needed. I certify that the information given is supported by the patient's medical record. Medicare requires that the physician retain information with patient's medical record that substantiates the patient's medical condition and justifies the need for the prescription.

*Physician Signature: (stamp not allowed, **MUST BE MD or DO**)*	*Date*	*NPI#*

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PHYSICIAN NAME: _____MD or DO

PHONE/FAX: _____