

Statement of Certifying Physician for Therapeutic Shoes

Patient: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus - ICD-9 Code:
(ICD-9 diagnosis codes 250.00 - 250.91)
2. This patient has one or more of the following conditions.
(Circle all that apply.)

DESCRIPTION

- 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 shoes) and/or inserts because of his/her diabetes.

Physician signature: _____

Date Signed: _____

Physician Name (printed): _____

Physician address: _____

Physician UPIN: _____

Physician Prescription Form

Patient's Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Phone(____) _____ Age _____ Patient's Medicare ID# _____

DX:

- ____ Previous Amputation
- ____ Previous Ulceration
- ____ Previous Pre-ulcer Callus
- ____ Peripheral Neuropathy
w/Callus Formation
- ____ Foot Deformity
- ____ Poor Circulation

RX:

- ____ Custom-Molded Shoes
- ____ Depth Shoes
- ____ Customized/Custom Orthosis
- ____ Roller-Bottom Sole or Bar
- ____ Rigid Rocker-Bottom Sole or Bar
- ____ Sole/Heel Wedge (Circle One)
- ____ Metatarsal Bar
- ____ Offset Heel
- ____ Other

ORTHOSIS: _____ LEFT _____ RIGHT

SHOE MODIFICATION: _____ LEFT SHOE _____ RIGHT SHOE

INSTRUCTIONS: _____

PRESCRIBING PHYSICIAN INFORMATION:

Signature _____

DEA # _____

Medicare UPIN # _____

Medicaid Provider # _____