

**STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES**

(to be completed by an M.D. or D.O.)

Date: \_\_\_\_\_ HIC#: \_\_\_\_\_  
 Account Number: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ Gender: \_\_\_\_\_

**I certify the following statements are true and I AM ATTACHING CHART NOTES to support each diagnosis. Medical Necessity for item(s) listed:**

1. **This patient has Diabetes Mellitus** \_\_\_\_\_ Insulin Treated \_\_\_\_\_ Non-Insulin Treated  
 (Fill in required ICD10 Code)

2. **This patient has one or more of the following conditions (check all that apply):**

- |  | <u>ICD10</u> |
|--|--------------|
| _____ A) History of partial or complete amputation of the foot   | _____        |
| _____ B) History of previous foot ulceration                     | _____        |
| _____ C) Peripheral neuropathy with evidence of callus formation | _____        |
| _____ D) History of pre-ulcerative callus                        | _____        |
| _____ E) Foot deformity  | _____        |
| _____ F) Poor circulation  | _____        |

3. \_\_\_\_\_ Yes \_\_\_\_\_ No **I am treating this patient under a comprehensive plan of care for his/her diabetes.**

4. \_\_\_\_\_ Yes \_\_\_\_\_ No **This patient requires diabetic shoes (extra depth or custom-molded) due to his/her diabetes.**

<b>Rx</b>	_____ Diabetic Shoes (off the shelf style)	Quantity = 2/each (1 Pair)	A5500
	_____ Diabetic Shoes, Custom Fabricated	Quantity = 2/each (1 Pair)	A5501
	_____ Diabetic insoles (off the shelf)	Quantity = 6/each (3 Pairs)	A5512
	_____ Diabetic insoles, Custom Fabricated	Quantity = 6/each (3 Pairs)	A5513, A5514
	_____ Toe Filler, Custom Fabricated	Quantity = 1/each	L5000

**Other** \_\_\_\_\_

**LENGTH OF NEED = 12 months**

NOTE: Prescribing physician (M.D., D.O.) may be different from certifying physician but must be knowledgeable in the fitting of diabetic shoes and inserts.

Physician's Printed Name: _____	NPI: _____
Address: _____	
Phone #: _____	Fax: _____
Physician's Signature: <b>X</b> _____	Date: <b>X</b> _____

## **WRITTEN ORDER FOR DIABETIC SHOES and DIABETIC INSOLES**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

<u>Description of prescribed items: (check all that may apply)</u>	<u>Quantity</u>
___ Diabetic shoes (off the shelf style) A5500	1 pair
___ Diabetic shoes (CUSTOM fabricated) A5501	1 pair
___ Diabetic insoles (off the shelf style) A5512	3 pairs
___ Diabetic insoles (CUSTOM fabricated) A5513, A5514	2 or 3 pairs
___ Toe filler (CUSTOM fabricated – for partial foot amputees)	1 each

Length of need: 12 months

Physician's  
Printed Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_