DETAILED PRESCRIPTION
Therapeutic Shoes for Persons with Diabetes

Patient Name: _____

Date of Birth: _____

Quantity	Order
1 2	**Off-the-Shelf Diabetic Shoe**: *A5500: For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi- density insert(s), per shoe*
1 2 3 4 5 6	**Multiple Density Inserts for Diabetic Shoes**: *A5512: For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each*

Physician Signature: X _____ **Date:** _____

Physician Name: NPI#:

PLEASE FAX BACK TO

American Medical Equipment at **(866) 593-7841**

CERTIFICATE OF MEDICAL NECESSITY / STATEMENT OF CERTIFYING PHYSICIAN For Therapeutic Shoes

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed below is present.

1) This patient has diabetes mellitus:

☐ Type I (E10.9) ☐ Type II (E11.9)

2) This patient has one or more of the following conditions (check all that apply):
   a. ☐ History of partial or complete amputation of the foot
   b. ☐ History of previous foot ulceration. (L97.909)
   c. ☐ History of pre-ulcerative callus. (L97.509)
   d. ☐ Peripheral neuropathy with evidence of callus formation (E10.40/E11.40)
   e. ☐ Foot deformity. (M21.969)
   f. ☐ Poor circulation. (E10.51/E11.51)

3) I am treating this patient under a comprehensive plan for care of his/her diabetes.

4) This patient needs special shoes (depth or custom-molded) because of his/her diabetes.

5) This patient needs shoe inserts (heat-molded or custom fabricated) because of his/her diabetes.

MD / DO Signature: X _____ **Date:** _____

Physician Name: NPI#:

FAX BACK A COPY OF THE PATIENTS CHART NOTES / FOOT EVALUATION