



Main Office
2620 Mineral Springs Ave. Suite A.
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Appointments Available
Knoxville, Lenoir City, Maryville and Sweetwater!

Prescription and Certificate of Medical Necessity for Diabetic Shoes and Inserts

PLEASE COMPLETE THE ENTIRE FORM AND FAX BACK WITH EXAM NOTES INCLUDING A FOOT EXAM AND RECENT A1C. MUST BE SIGNED BY MD OR DO.

PATIENT NAME: _____ DOB: _____

DATE OF LAST FOOT EXAM: _____ DIAGNOSIS (ICD 10): _____

I certify that all the following statements are true:

- 1. This patient has diabetes mellitus. YES OR NO**
- 2. This patient has one of 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. YES OR NO**

Prescription. Please select Items to be Supplied:

- | | |
|--|--|
| <input type="checkbox"/> A5500 Standard Diabetic Shoes | <input type="checkbox"/> A5501 Custom Made Diabetic Shoes |
| <input type="checkbox"/> A5513 Custom Diabetic Foot Orthotics | <input type="checkbox"/> A5512 Heat Moldable Diabetic Foot Orthotics |
| <input type="checkbox"/> L5000 Toe Filler for Amputations (1 orthotic) | |

Physician Signature: _____ **Date:** _____

Signature must be complete by and M.D. or D.O.

Physician name: _____ NPI#: _____

Physician Address: _____

Physician Phone Number: _____ Physician Fax Number: _____