The DiABETiC Shoppe

1068 Factory Drive ~ Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-800-520-8117

Diabetic Shoes & Inserts Prescription Form

Step 1

Patient ID#:_____   Effective Date:_____

Patient Name: Mr/Ms_____   SS#:_____

Address:_____ City:_____,_____ Zip:_____

Phone:_____   Birthday:_____

Primary:_____   Secondary:_____

Policy #:_____   Policy #:_____

Therapeutic shoes and inserts are designed to **prevent** complications that could lead to an amputation.

Diabetic Shoes (A5500) 1 pair   Custom-Molded Inserts (A5514) 3 pair

Other:_____

I CERTIFY ALL OF THE FOLLOWING STATEMENTS ARE TRUE: PLEASE CHECK

Step 2

1. This patient has Diabetes Mellitus. ❑ E11.9 ❑ E11.65 ❑ E10.9 ❑ E10.65 - Insulin Treated? Yes _ No _
2. This patient has one or more of the following conditions:
    _____ History of partial or complete amputation of the foot   ❑ _____
    _____ History of previous foot ulcerations   ❑ L97.909, or ❑ _____
    _____ History of pre-ulcerative callous   ❑ L84, ❑ L97.909, or ❑ _____
    _____ Peripheral neuropathy with evidence of callous formation   ❑ E11.40, ❑ E10.40, or ❑_____
    _____ Foot deformity   ❑ M21.6X9, or ❑ _____
    _____ Poor circulation   ❑ E11.51, ❑ E10.51, or ❑ _____
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) because of his/her diabetes.

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*The above information is true, accurate and complete to the best of my knowledge. By my signature below I certify that the patient has diabetes and is/was being treated by me, and has been seen in the last six months. All the information contained in this written Doctors Order form accurately reflects the patient's diabetic condition and the treatment regimen that I have Prescribed. The medical records for this patient substantiate the conditions. For Medicare / insurance requirements, I will maintain this signed original in the patient's medical record file.

Step 3

Print Physician's Name:_____ Ph:_____ Fax_____

Prescribing Phys Sign:_____ NPI:_____ DEA_____ Date:_____

Certifying Phys Sign:_____ NPI:_____ DEA_____ Date:_____