

## 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 (A5513) 3 pair  
Other: \_\_\_\_\_

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

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.

\*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 2

Print Physician's Name: \_\_\_\_\_ Ph: \_\_\_\_\_ Fax \_\_\_\_\_  
Prescribing Phys Sign: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA \_\_\_\_\_ Date: \_\_\_\_\_  
Certifying Phys Sign: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA \_\_\_\_\_ Date: \_\_\_\_\_

Step 3



Accredited by  
JCAHO