GROVE PARK PHARMACY
MEDICAL EQUIPMENT and HOSPICE CARE

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DIABETIC SHOES PRESCRIPTION AND CERTIFICATION

NAME: _____ DOB: _____ LENGTH OF NEED: _____

PROC. CODE	ITEM/DESCRIPTION	QUANTITY ORDERED
A5500	DIABETIC SHOE	2
A5512	DIABETIC SHOE INSERT	6

ICD-10 CODE	DIAGNOSIS DESCRIPTION
E11.9	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
_____	_____
_____	_____

CERTIFICATION
(M.D. OR D.O. ONLY)

I CERTIFY THAT ALL OF THE FOLLOWING STATEMENTS ARE TRUE:

1. THIS PATIENT HAS DIABETES ○ Type I ○ Type II
2. I AM TREATING THIS PATIENT UNDER A **COMPREHENSIVE PLAN OF CARE** FOR HIS/HER DIABETES.
3. THIS PATIENT NEEDS SPECIAL SHOES (DEPTH OR CUSTOM-MOLDED SHOES) BECAUSE OF HIS/HER DIABETES.
4. THIS PATIENT HAS ONE OR MORE OF THE FOLLOWING CONDITIONS: (CIRCLE ALL THAT APPLY)
   a) HISTORY OF PARTIAL OR COMPLETE **AMPUTATION OF THE FOOT** *(ICD-10 code: _____)*
   b) HISTORY OF **PREVIOUS FOOT ULCERATION** **(***ICD-10 code: _____)*
   c) HISTORY OF **PRE-ULCERATIVE CALLUS** *(ICD-10 code: _____)*
   d) PERIPHERAL NEUROPATHY *WITH* EVIDENCE OF CALLUS FORMATION *(ICD-10 code: _____)*
   e) FOOT **DEFORMITY** *(ICD-10 code: _____)*
   f) POOR **CIRCULATION** *(ICD-10 code: _____)*

MD/DO NAME _____ PHYSICIAN SIGNATURE _____ DATE: _____
NPI #: _____

Please attach MD/DO (from above) chart notes within the last 4-5 months that address this patient's diabetic management AND the foot exam with at least one of the above listed foot conditions.