Prescription for Therapeutic Footwear

Patient Name: _____

Date of Birth: _____

Check all that apply:

- □ Diabetes Mellitus (E11.9)
- □ Hammertoe(s)
- □ Bunion(s)
- □ Ulcer(s)
- □ Callus(es)
- □ Amputation(s)
- □ Charcot Deformity
- □ Fascitiis
- □ Edema
- □ Neuroma
- □ Corn(s)
- □ Ankle instability
- □ Drop foot
- □ Posterior Tib. Disorder
- □ Peripheral Vasc. Dis.
- □ Neuropathy

The patient requires:

□ Diabetic Footwear, non custom (A5500) x 2

With:

□ Non custom, heat moldable inserts (A5512) x 6

□ Toe Filler (L5000)

Comments:_____

_____

Clinician Name:_____

Signature:_____ **Date**:_____

Statement of Certifying Physician

Patient Name_____ DOB_____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD-10 _____ (ICD-10 codes E08 – E13.9)
2. This patient has one of the following conditions:
   Check all that apply
   - □ History of partial or complete amputation of the foot
   - □ Peripheral neuropathy with evidence of callus formation
   - □ History of previous foot ulceration
   - □ Foot deformity
   - □ History of pre-ulcerative callus
   - □ Poor circulation
3. I am treating this patient under a comprehensive plan and care for his/her diabetes.
4. This patient needs special shoes (depth or custom molded) and/or inserts because of his/her diabetic condition.

Certifying Physician Information: (must be signed by a MD or DO)

Signature:_____ **Date**:_____

Name:_____

NPI #:_____ Enrolled in PECOS? Y N