## Prescription for Diabetic Shoes and Inserts

Date:________________

Patient Name:______________________________________________

DOB:____________ Phone #:__________________________________

**TYPE OF SHOES:**

☐ Extra Depth (A5500) - 1 pair

**TYPE OF INSERTS:**

☐ Heat Moldable (A5512) - 3 pairs

☐ Custom Fabricated (K0903) - 3 pairs

☐ Other:________________________________________________

**ICD NOTES & SPECIAL INSTRUCTIONS:**

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__________________________________________________________

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Physician's Signature (M.D., D.O., D.P.M., P.A., N.P., or CNS)

__________________________________________________________

Physician's Name NPI #

__________________________________________________________

Address Phone #

## Statement of Certifying Physician

Date:________________

Patient Name:______________________________________________

DOB:____________ Phone #:__________________________________

**I certify that all the following statements are true:**

1. This patient has diabetes mellitus: ☐ Type I ☐ Type II
2. This patient has one or more of the following conditions:
   - ☐ History of partial of complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ Poor circulation
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 shoes) because of his/her diabetes.

__________________________________________________________

Physician's Signature **(MUST BE AN M.D., D.O., or N.P.)**

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Physician's Name NPI #

__________________________________________________________

Address Phone #

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