Patient name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (____) ____ - _____ Date of Birth: ___/___/_____
Medicare ID #: _____

Medicare Shoe Prescription for Diabetic Patients

Dx:

__ Previous Amputation
__ Previous Ulceration
__ Previous Pre-Ulcer Callus
__ Peripheral Neuropathy with Callus Formation
__ Foot Deformity
__ Poor Circulation

Rx:

__ Custom Molded Shoes
__ Depth Shoes
__ Customized/Custom Orthotics
__ Diaba-soles, Non Customized
__ Rocker Bottom Sole or Bar
__ Rigid Rocker / Steel Shank
__ Sole / Heel Wedge
__ Metatarsal Bar
__ Offset Heel
__ Other

Orthosis: ____ Left ____ Right
Shoe Modifications: ____ Left shoe ____ Right shoe

Dispense: 1 pair / 2 pair / 3 pair

Instructions:_____

_____

Prescribing physician information:

Physician signature: _____

Physician name (stamp):

Physician address:

Physician Phone #

Physician UPIN: _____

Date signed: _____

Statement of Certifying Physician for Therapeutic Shoes

I Certify that all of the following statements are true:

1. **This patient has Diabetes Mellitus ICD-9 Code***: _____
   (ICD-9 Code must be to the fifth digit)

2. This patient has one or more of the following conditions. (Circle all that apply):

   a) History of partial or complete amputation of the foot.
   b) History of previous foot ulceration.
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   e) Foot deformity
   f) 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) and or insets because of his/her Diabetes.

Physician signature: _____

Physician name (stamp):

Physician address:

Physician Phone #

Physician UPIN: _____

Date signed: _____

* ICD-9 Codes:

Because the benefit is available **only** to diabetic patients, an qualifying ICD-9 code (250.00-250.91) is required on the certification statement.

***** This certification can NOT be completed by a podiatrist *****