A D MEDICAL, INC.

America's Dietitians

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www.americasdietitians.com

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Name: ______________________ Phone: ______________________

Address: ______________________ Sex: ☐ **M** ☐ **F**

City: ______________________ State: __________ Zip: ______________

DOB: ______________ Medicare: ______________ Secondary: ______________

I certify that all of the following statements are true and documented in the patient notes.

1) This patient has diabetes mellitus ☐ E11.9 or ☐ E10.9 or ☐ Other: ______________
2) This patient has one or more of the following conditions:

Check all that apply:	**Please circle**	**/ ICD-10-CM**
a) History of partial or complete amputation of the foot. (S98)	**L** or **R**	__________
b) History of previous foot ulceration. (Z86.31)	**L** or **R**	__________
c) History of pre-ulcerative callus. (L84)	**L** or **R**	__________
d) Foot deformity. (M20.60 or M21.969)	**L** or **R**	__________
e) Poor circulation. (I99.8)	**L** or **R**	__________
f) Peripheral neuropathy with evidence of callus formation. (G57)	**L** or **R**	__________

3) I am treating this patient under a comprehensive plan for his/her diabetes and by signing below, I certify that it is medically necessary for the above named patient to receive:

One (1) pair of depth-inlay shoes (A5500) and three (3) pairs of custom (A5513) or heat-moldable (A5512) inserts.

Physician Signature: ______________________________ Date: __________
(Must be **MD** or **DO**)

Physician: ______________________________ NPI: ______________

Address: ______________________ City: __________ State: ______ Zip: __________

Phone: ______________________ Fax: ______________________

*****THESE ARE 2 SEPARATE FORMS AND MUST BE FILLED OUT ENTIRELY*****

Prescription form for Therapeutic Footwear: Depth shoes and Inserts

Patient Name: ______________________________ DOB: ______________

ITEMS TO BE DISPENSED:

☐ One pair Depth Shoes (A5500) with 3 pair Custom Fabricated Inserts (A5513)
☐ One pair Depth Shoes (A5500) with 3 pair Heat Moldable Inserts (A5512)

Prescriber Signature: ______________________________ NPI: ______________

Prescriber's Name: ______________________________ Date: ______________

(Printed – May be **MD**, **DO**, **DPM**, **PA**, **NP**, **CNS**)

PLEASE COMPLETE AND FAX TO 888-785-7380