The DiABETiC Shoppe
6629 MS Highway 32E ~ Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-888-377-2224

Diabetic Shoes & Inserts Prescription Form

Step 1

Patient ID#:_____ Effective Date:_____

Patient Name: Mr/Ms_____ SS#:_____

Address:_____ City:_____,_____ Zip:_____

Phone:_____ Birthday:_____

Primary:_____ Secondary:_____

Policy #:_____ Policy #:_____

Therapeutic shoes and inserts are designed to **prevent** complications that could lead to an amputation.

Diabetic Shoes (A5500) 1 pair Custom-Molded Inserts (A5513) 3 pair

Other:_____

I CERTIFY ALL OF THE FOLLOWING STATEMENTS ARE TRUE: PLEASE CHECK

Step 2

1. This patient has Diabetes Mellitus. ❑ E11.9 ❑ E11.65 ❑ E10.9 ❑ E10.65
2. This patient has one or more of the following conditions:
   - _____ History of partial or complete amputation of the foot ❑ _____
   - _____ History of previous foot ulcerations ❑ L97.909, or ❑ _____
   - _____ History of pre-ulcerative callous ❑ L84, ❑ L97.909, or ❑ _____
   - _____ Peripheral neuropathy with evidence of callous formation ❑ E11.40, ❑ E10.40, or ❑_____
   - _____ Foot deformity ❑ M21.6X9, or ❑ _____
   - _____ Poor circulation ❑ E11.51, ❑ E10.51, or ❑ _____
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) because of his/her diabetes.

*The above information is true, accurate and complete to the best of my knowledge. By my signature below I certify that the patient has diabetes and is/was being treated by me, and has been seen in the last six months. All the information contained in this written Doctors Order form accurately reflects the patient's diabetic condition and the treatment regimen that I have Prescribed. The medical records for this patient substantiate the conditions. For Medicare / insurance requirements, I will maintain this signed original in the patient's medical record file.

Step 3

Print Physician's Name:_____ Ph:_____ Fax_____

Prescribing Phys Sign:_____ NPI:_____ DEA_____ Date:_____

Certifying Phys Sign:_____ NPI:_____ DEA_____ Date:_____

Accredited by
JCAHO