DETAILED WRITTEN PRESCRIPTION ORDER & MEDICAL NECESSITY FOR THERAPEUTIC SHOES & INSERTS FOR DIABETICS

Patient Information:

Name: _____ Phone: _____ D.O.B: _____

Address: _____ City: _____ State: _____ Zip:_____

Primary Insurance: _____ Primary Insurance ID: _____ M / F

Physician's Order: (Check all that apply/ choose either prefabricated or custom inserts)

___ A5500- For diabetics only, fitting (including follow-up) custom preparation and supply of off-the-shelf depth inlay shoes manufactured to accommodate multi-density inserts, per shoe. **QTY: (1) One Pair**

___ A5501- For diabetics only, fitting (including follow up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), **QTY: (1) One Pair**

___A5513- For diabetics only, multi-density inserts custom molded from model of patient's foot. Total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a durometer or higher, includes arch filler and other shaping material, **custom fabricated,** each. **QTY: (3) Three Pair**

___A5512- For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degree Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), **prefabricated,** each. **QTY: (3) Three Pair**

___L5000- Partial foot, shoe insert with longitudinal arch, Toe Filler ____**left** ____**right**

Certification of Medical Necessity:
Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if the following criteria are met**:**

1. The patient listed above has diabetes mellitus (ICD-9 codes 249.00-250.93): (**Check ICD-9 that applies)**

____ 250.00 ____250.01 ____250.02 ____250.03 ____other:_____

2. In order to meet **Medical Necessity,** the certifying physician has documented in the patient's medical record one or more of the following conditions or has obtained, initialed and dated (prior to signing the certification statement), and indicate agreement with information from the medical records of a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that documents one or more of diagnosis criteria selected.: (**Check all that apply)**

____ History of foot ulceration (707.70-707.9) ____ History of pre-ulcerative callus (700)

____Poor Circulation (250.7) ____History of partial/complete amputation of the foot (869.0)

____ Foot deformity (736.70) ____Peripheral neuropathy with evidence of callus (250.6)

"By signing below I am certifying that this patient is under a comprehensive plan of care for diabetes mellitus and that he/she needs extra depth shoes with multiple inserts because of his/her diabetes. By signing below I also attest that the medical record entry for this patient accurately reflects signatures/notations that I made in my capacity when I treated/diagnosed the above listed beneficiary. I do hereby attest that the information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability."

Physician Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

PLEASE FAX COMPLETED PRESCRIPTION BACK TO: F 718•677•9065, TEL 718•677•9066
Include a copy of the patient's progress notes from the last office visit.
Medicare requires medical history pertaining to diagnoses be on file upon request.