Diabetic & Therapeutic Shoes

Statement of Certification

Start Date:_____ Note: Start date is date of prescription

Section 1: Patient Information:

Patient Name_____ Date of Birth____/____/_____
Length of Need__99 mos._____ Patient Height:_____ Weight:_____ lbs.

Section 2: Medical Information:

I certify that all the following medical information/statements are true:

1. **This patient has diabetes mellitus, with the ICD 10 code below:**

   Please provide the ICD 10 code here**: E**_____

2. **This patient has one or more of the following conditions, check all that apply**

   - ☐ History of partial or complete amputation of the foot, or
   - ☐ History of previous foot ulceration, or
   - ☐ History of pre-ulcerative calluses, or
   - ☐ Peripheral neuropathy with evidence of callus formation, or
   - ☐ Foot deformity, or
   - ☐ Poor circulation

3. **I am treating this patient under a comprehensive plan of care for his/her diabetes**
4. **The patient needs diabetic/therapeutic shoes because of his/her diabetes**

Section 3: Equipment Information:

Amount	HCPC	Description
2	A5500	FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF OFF-THE-SHELF DEPTH-INLAY SHOE MANUFACTURED TO ACCOMMODATE MULTI-DENSITY INSERT(S), PER SHOE
6	A5512	EACH FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230°F OR HIGHER, TOTAL CONTACT WITH PATIENTS FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF ¼ IN MATERIAL OF SHORE A 35 DUROMETER, OR, 3/16 IN MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH
6	A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATEINTS FOOT, TOTAL CONTACT WITH PATIENTS FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 IN MATERIAL OF SHORE A 35 DUROMETER (OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED EACH

Physician Signature and date:

I attest that I have reviewed this detailed order and it is a correct and accurate representation of my patient and prescription. I further certify that this equipment was necessary for the patient to function in the completion his his/her MRADL's.

Physician Signature_____ Date:____/____/_____

Physician Name:_____ NPI:_____

PLEASE NOTE: Original Prescription should accompany this form