STATEMENT OF CERTIFYING PHYSICIAN DIABETIC THERAPEUTIC FOOTWEAR

(This form must be signed by the D.O. or M.D. caring for the patient's diabetic condition.)

PATIENT:_____

PHONE:_____ DATE:_____

MEDICARE #:_____

SUPPLEMENT #:_____

I certify that all of the following indicated statements are true and are noted in the patient's chart. (check all that apply):

1. This patient has diabetes mellitus. ICD9: Code_____(250.00 – 250.91)

2. This patient has one or more of the following conditions (CHECK ALL THAT APPLY)

_____ A. History of partial or complete amputation of 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

2. I am treating this patient under a comprehensive plan of care for Diabetes.
3. This patient needs special footwear (depth or custom molded footwear) and / or inserts because of their diabetic condition.

4. This patient is _____ insulin dependent / _____ non-insulin dependent.

Physicians Signature:_____ **Date:**_____

Physicians Name (printed):_____

Physicians Address:_____

Physicians Phone:_____**NPI**_____

THESE ARE 2 SEPARATE FORMS AND BOTH MUST BE FILLED OUT IN ENTIRETY

Prescription Form for Therapeutic Footwear

(Prescribing physician may be a D. O., M. D. or D. P. M. and may be different from certifying physician.)

PATIENT:_____ DOB:____/_____/_____

Prescription:

_____ **1 Pair Extra Depth Shoes (A5500)**

_____ **3 Pair of Heat Moldable Inserts (A5512)**

_____ **3 Pair of Custom Molded Orthotics (A5513)**

Physicians Signature:_____ Date:_____

Physicians Name (printed):_____

Physicians Address:_____

Physicians Phone:_____NPI_____

WINFIELD PHARMACY

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