Therapeutic Footwear - Patient Billing Information - Delivery Ticket Form and Prescription For Therapeutic Shoes

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Patient's Phone: _____ Footwear Consultant: _____

Patient's SS #: _____ Medicare #: _____

Secondary Insurance: _____ Address: _____

Diabetic Shoes / Orthotic Inserts

Shoe Type: ☐ Lace ☐ Velcro ☐ Men's ☐ Women's ☐ Lycra ☐ Leather Size: _____

Inserts: Number of Inserts: _____

Statement of Certifying Physician for Therapeutic Shoes/Insoles

I certify that all the following statements are true;

1. This Patient has diabetes mellitus. (Please check)
   - ☐ Insulin Dependent *or* ☐ Non Insulin Dependent
   - ☐ Controlled *or* ☐ Uncontrolled
2. Please state from the patient's medical record (or attach a copy), indicating the nature of the foot disorder that warrants the need for shoes. This patient has one or more of the following conditions:
   a. History of partial or complete amputation of the foot.
   b. History of previous foot ulceration
   c. Peripheral neuropathy with evidence of callus formation
   d. History of pre-ulcerative callus
   e. Foot Deformity
   f. Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.

Please check the diagnoses that apply

☐ Neuroma of amputation stump 997.61	☐ Traumatic amputation of toe without complication 895.0	☐ Traumatic amputation of toe(s) with complication 895.1
☐ Corns and Callosities 700	☐ Bone Spur 726.91	☐ History of amputation of great toe V49.71
☐ Open wound of toe(s) without complication 893.0	☐ Open wound of toe(s) with complication 893.1	☐ History of amputation of other toe(s) V49.72
☐ Great toe angles toward other toes 735.0	☐ Great toe angles away from other toes 735.1	☐ Other acquired deformities of the toe 735.8

☐ Diabetes with peripheral circulatory disorders 250.7	☐ Gangrene 785.4

Physician's Name: _____ Phone: _____ Fax: _____

Physician's Address: _____ City: _____ State: _____ Zip Code: _____

Physician's Signature: _____ UPIN: _____ Date: _____

I hereby authorized payment of medical benefits to _____ for services furnished. I further authorize the release of any medical information required to process Insurance claims on my behalf. I hereby permit a copy of this authorization to be valid as the original.
I understand that all costs of devices and supplies not paid for by my insurance company will become my responsibility.

The footwear has been properly fitted with heat molded inserts and delivered to meet my needs and I have been given the Medicare Supplier Standards form.

Patient's Signature: _____ Date: _____

If unable to sign - Why?: _____ Caregiver - Authorized Signature: _____