Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

HIC #: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
   a) History of partial or complete amputation of the 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
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 shoes) because of his/her diabetes.

Physician signature: _____

Date Signed:_____

Physician name (printed - MUST BE AN M.D. OR D.O.):

_____

Physician address:

_____

_____

_____

Physician NPI: _____

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ROME, GA 30165
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WALKER ORTHOTICS AND PROSTHETICS

205 REDMOND ROAD •ROME GA 30165•P(706)232-4383•F(706)232-4667

DETAILED WRITTEN ORDER

NAME:	DOB:	HIC#:	CHART#:
ADDRESS:	CITY:	STATE:	PHONE #

Primary ICD 10 Diagnosis Code _____ Other applicable ICD 10 codes _____, _____, _____

# UNITS	HCPCS CODE	PRESCRIPTION/DESCRIPTION
	A5500	For diabetics only (including follow-up), custom preparation and supply of the of the shelf depth inlay shoe manufactured to accommodate multi density insert (s), per shoe
	A5501	For diabetics only (including follow-up), custom preparation and supply of shoe molded from casts of patients foot (per shoe)
	A5513	For diabetics only, multiple density insert (s), custom molded, per shoe
	A5512	For diabetics only, multiple density inserts (s), per shoe

Special Instructions_____

_____

The above patient has been under my care for management of diabetes. It is medically necessary for patient to be evaluated and fit for diabetic shoes and/or inserts due to the health issues as indicated in my notes and/or marked on the Statement of Certifying Physician.

M.D./D.O- Treating Physician Signature:_____Date:_____

Physician Information		
Name:	Address:	NPI:
Phone #:	Fax#:	

***In order for us to complete fitting of patient's diabetic shoes and/or inserts, please fax this form along with RX, your notes and signed Statement of Certifying Physician to 706-232-4667 or give paperwork to patient to return to our office.**