

615 S.L. ROGERS WELLS BLVD.

GLASGOW, KY 42141

270.651.8889 PHONE

270.651.6198 FAX

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY INS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapeutic shoes and inserts are designed to **prevent** complications that could lead to amputation.

**DIABETIC SHOES (A5500):\_\_\_\_\_ MULTI- DENSITY INSERTS (A5512): \_\_\_\_\_**

**I CERTIFY ALL OF THE FOLLOWING STATEMENTS ARE TRUE:** PLEASE CHECK ALL THAT APPLY

1. This patient has Diabetes Mellitus. \_\_\_ E11.9 \_\_\_E11.65 \_\_\_E10.9 \_\_\_ E10.65
2. This patient has one of more of the following conditions:

\_\_\_ History of partial or complete amputation of the foot: \_\_\_\_\_

\_\_\_ History of previous foot ulcerations: \_\_\_ L97.909 or \_\_\_\_\_

\_\_\_ History of pre-ulcerative callous: \_\_\_\_L84 \_\_\_\_L97.909 or \_\_\_\_\_

\_\_\_ Peripheral neuropathy with evidence of callous formation: \_\_\_\_E11.40 or \_\_\_\_\_

\_\_\_ Foot deformity: \_\_\_\_ M21.969 or \_\_\_\_\_

\_\_\_ Poor circulation: \_\_\_\_ E11.51 or \_\_\_\_\_

1. I am treating this patient under a comprehensive plan of care for his/her diabetes.
2. This patient needs special shoes (depth or custom molded) due to his/her diabetes.

The above information is true, accurate and complete to the best of my knowledge. By my signature below I certify that the patient has diabetes and is/was being treated by me and has been seen within the last six months. All the information contained in this written Doctors Order form accurately reflects the patient’s diabetic condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the conditions. For the Medicare/ insurance requirements. I will maintain this signed original in the patient’s medical record file.

PRINT PHYSICIANS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WE OFFER THE FOLLOWING BRANDS:** NEW BALANCE, AETREX, **DR. COMFORT, & DREW**