DIABETIC CERTIFICATION
FOR THERAPEUTIC FOOTWEAR
By Appointment Only

Walkwell Shoes
413 Springfield Avenue
Summit, NJ 07901
Phone (908)273-7979
Fax (908)273-7617

Date_____

Patient's Name_____

Address_____

City_____State_____Zip Code_____

Date of Birth_____/_____/_____

1. The patient has diabetes mellitus (ICD-9 Code)_____
2. The patient has **at least one** of the following: **(Please circle all that apply and add to patient's chart)**
   a. Poor circulation of either foot
   b. Foot deformity of either foot (bunions, hammer toes, etc.)
   c. Peripheral neuropathy with callus formation on either foot
   d. History of pre-ulcerative calluses
   e. History of previous foot ulceration
   f. Previous amputation of part of either foot
3. Therapeutic shoes are a part of a comprehensive plan of care in treating the patient.

_____Insulin _____Non-insulin

Prescribing Physician: (signature)_____ **M.D. or D.O. only per Medicare Requirements**

(print name)_____

Are you enrolled in Medicare's PECOS system? (circle one) YES NO

NPI#_____

Prescription:

_____ Extra Depth Shoes with 3 pairs of molded inserts or modifications; or custom molded footwear

_____ Modifications or other instructions _____

_____