Statement of Certifying Physician for Therapeutic Shoes

Patient Name_____Policy#_____
Patient Telephone _____ Date of Birth_____

This section to be completed by physician treating Diabetes. Must be MD or DO.
Please include records used to complete this form.

I certify that all the following statements are true and are documented in the patient's medical records:
1. This patient has Diabetes Mellitus. ICD-10 CODE _____
2. Date of the patient's most recent office visit _____
3. This patient has one or more of the following conditions that have been documented in their medical records within the last six months (Check all that apply):

__ History of partial or complete amputation of the foot
__ History of pre-ulcerative callus on either foot
__ Peripheral neuropathy with evidence of callus formation on either foot
_History of previous foot ulceration
_Foot deformity of either foot
_Poor circulation of either foot

4. I am treating this patient under a comprehensive plan of care for his/her diabetes. Yes___ No___
5. Patient needs special shoes (depth or custom molded) and/or inserts due to his/her diabetes. Yes___ No___

PHYSICIAN SIGNATURE Must be MD or DO. Original signature only. No signature stamp.
Signature_____Date_____
Physician Name _____
Practice Name _____
Street _____
City_____ State_____ ZIP_____
Phone # _____ Fax #_____NPI#_____

Prescription for Therapeutic Footwear

This section to be completed by MD, DO or DPM.
Items must be fitted within three months of physician's signature or this Rx will be considered VOID.

Rx - Please dispense the following (Check one only):
__ One Pair of Extra Depth Diabetic Shoes / Three Pairs of Diabetic Inlays
__ One Pair of Extra Depth Diabetic Shoes / Three Pairs of Custom Molded Inlays
__ One Pair of Custom Molded Diabetic Shoes / Two Extra Pairs of Custom Molded Inlays
__ Amputation Toe Filler/Foot Filler Right___ Left_____
_Other Please explain)_____
Duration of use: 12 months. ICD-10 CODE to justify the need for the items being prescribed._____

PHYSICIAN SIGNATURE Must be MD, DO or DPM. Original signature only. No signature stamp.

Signature_____Date _____

Physician Name_____
Practice Name_____
Street _____
City_____ State_____ ZIP_____
Phone # _____ Fax # _____ NPI#_____

Walkwell Shoes, **413 Springfiled Ave., Summit, NJ** I *phone* **908.273.7979** I *fax* **908.273.7617**

Certified Pedorthic Facility & Professional Orthotics @walkwellshoes.com