Walk Well
PROFESSIONAL SHOE FITTERS
Certified Pedorthists
413 Springfield Avenue, Summit, NJ 07901
908.273.7979

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____ **Birthdate: / /**

ICD 10: _____

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: _____

Walk Well Shoes Fax number: 908 273-7617

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 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 _____

PhysicianName_____
PracticeName_____
Street_____
City_____ State_____
ZIP_____
Phone # Fax #
NPI#_____

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

Certified Pedorthic Facility & Professional Orthotics
@walkwellshoes.com