Date: [Date]

To: [Provider Name/Facility Name]
Address: [Provider Address]
Fax/Phone: [Provider Contact Information]

RE: Prescription for Diabetic Footwear and Custom Orthotics

Patient Name: [Patient Name]
Date of Birth: [DOB]
ICD-10 Code(s): [e.g., E11.9, E11.40, E11.51]

Dear [Provider Name],

I am treating the patient listed above for diabetes mellitus. I am referring this patient for a footwear evaluation and the provision of diabetic shoes and custom-molded inserts.

I certify that this patient meets the following criteria:

- The patient has diabetes mellitus.
- The patient has one or more of the following conditions (check all that apply):
  [ ] Previous amputation of the other foot or part of either foot.
  [ ] History of previous foot ulceration.
  [ ] Pre-ulcerative callous formation.
  [ ] Peripheral neuropathy with evidence of callus formation.
  [ ] Foot deformity.
  [ ] Poor circulation.
- I am managing this patient's systemic diabetes condition under a comprehensive plan of care.
- This patient requires therapeutic shoes and/or inserts to prevent ulceration or further injury.

Prescription:

- **A5500:** For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe. (Quantity: 1 pair)
- **A5513:** For diabetics only, multiple density insert, custom molded to patient's foot. (Quantity: 3 pairs)

Physician Information:

Signature: ________________________________
Print Name: [Physician Name]
NPI Number: [NPI Number]
Phone: [Phone Number]