DIABETIC THERAPEUTIC FOOTWEAR PRESCRIPTION

Patient Name: _____
Date of Birth: _____
Date of Last Visit: _____

ICD-10 Diagnosis Codes:
[ ] E11.9 Type 2 diabetes mellitus without complications
[ ] E11.40 Type 2 diabetes mellitus with diabetic neuropathy
[ ] E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy
[ ] Other: _____

Qualifying Conditions (Check all that apply):
[ ] Previous amputation of the foot or part thereof
[ ] History of previous foot ulceration
[ ] Pre-ulcerative callus formation
[ ] Peripheral neuropathy with evidence of callus formation
[ ] Foot deformity (e.g., bunions, hammer toes, Charcot foot)
[ ] Poor circulation (Peripheral Vascular Disease)

Prescription:
[ ] Extra-depth shoes (1 pair)
[ ] Heat-molded, multiple density inserts (3 pairs)
[ ] Custom-molded multiple density inserts (3 pairs)

Physician Statement:
I certify that this patient has diabetes mellitus and is being treated under a comprehensive plan of care for their diabetes. This patient has one or more of the qualifying conditions listed above and requires therapeutic shoes and/or inserts to prevent foot ulcers or further complications.

Physician Name: _____
NPI Number: _____
Phone Number: _____
Physician Signature: _____
Date: _____