

**PHYSICIAN CERTIFICATION / PRESCRIPTION
AND PATIENT AOB / ACCEPTANCE FOR THERAPEUTIC FOOTWEAR**

NAME:	DOB	HIC#	Chart#
ADDRESS:	City	State	Phone #:

I CERTIFY THAT ALL THE FOLLOWING STATEMENTS ARE TRUE:

1. This patient has diabetes mellitus. ICD -9 Code (**Check all that apply**)

_____ 250.00 - Diabetes mellitus type II (NIDDM type) (adult - onset type) or unspecified type, not stated as controlled

_____ 250.01 - Diabetes mellitus type I (IDDM) (juvenile type), not stated as uncontrolled

_____ 250.02 - Diabetes mellitus type II (NIDDM type) (adult onset type) or unspecified type, uncontrolled

_____ 250.03 - Diabetes mellitus type I (IDDM) (juvenile type), uncontrolled

Other ICD - 9 Codes / Notes:

2. This patient has one or more of the following conditions: (check all that apply)

** This should be consistent with the encounter forms and " diabetic patient summary, tracking, and schedule sheet."

_____ * History of partial or complete amputation of the foot	_____ * Ankle instability
_____ * History of previous foot ulceration	_____ * Foot deformity
_____ * History of pre-ulcerative callus	_____ * Poor circulation
_____ * Peripheral Neuropathy with evidence of callus formation	_____ * Chronic pain

3. I am treating this patient under a comprehensive plan or care for his/her diabetes.

4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

# UNITS	HCPCS Code	Prescription / Description
1 2 3 4	A5500	For diabetics only, fitting (including follow-up), custom preparation and supply of the off the shelf depth inlay shoe manufactured to accommodate multi density insert (s), per shoe
2 3 4 6	A5512	For diabetics only, multiple density insert (s), per shoe
2 3 4 6	A5513	For diabetics only, multiple density custom fabricated insert (s),molded and formed directly to a model of the patient's foot.

M.D. / D.O. - Prescribing Physician Signature: _____ **Date:** _____

Physician Information

Name: _____ **Address:** _____ **NPI:** _____

Office #: _____ **Office Fax #:** _____

Employee Certification

I certify, (a) the above named patient has received the above marked shoes and /or inserts (b) that the documentation contained in the chart is consistent with the diagnosis and conditions marked on this form (c) that the patient's condition (s) and diagnosis (s) have been explained to the patient and every reasonable effort has been made to insure the patient understands their diagnosis (s) and condition (s); (d) the patient has been fitted and has accepted and is satisfied with the shoes and inserts provided for them.

Signature: _____ Date: _____

Patient Certification

I certify, (a) I have received the above marked therapeutic shoes and inserts, (b) my condition (s) and diagnosis (s) have been explained to me. (c) I understand the importance of self care and compliance with the treatment plan by my physician. (d) I am satisfied with the shoes and inserts I received from this health care provider. (e) I have been given the option of having the shoes and inserts provided by another provider but have elected to have them provided by this physician/ facility. This facility has my permission to file for and receive reimbursement from my insurance carrier (s) in my behalf. I further certify the information recorded above is true and correct. I understand I am responsible for non covered or unpaid services. I acknowledge that Dr. Comfort will accept returns of any shoes, without question, within 30 days of dispensing and that acceptance of any return outside this period is at the sole discretion of Dr. Comfort.

Signature: _____ Date: _____

Thank you for allowing us to Serve you!