

**Therapeutic Footwear - Patient Billing Information - Delivery Ticket Form and Prescription For Therapeutic Shoes**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Patient's Phone: \_\_\_\_\_ Footwear Consultant: \_\_\_\_\_  
 Patient's SS #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_  
 Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Diabetic Shoes / Orthotic Inserts**

Shoe Type:  Lace     Velcro     Men's     Women's     Insert Custom Molded from Model of Patient's Foot  
 Lycra     Leather    Size: \_\_\_\_\_     Insert Heat Moldable

**Statement of Certifying Physician for Therapeutic Shoes/Insoles**

I certify that all the following statements are true;

1. The Patient has diabetes mellitus. (Please check one from each column)
 

<input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Non Insulin Dependant
<input type="checkbox"/> Controlled	<input type="checkbox"/> Insulin Dependant
2. This patient has one or more of the following conditions:
 

a. History of partial or complete amputation of the foot.	d. History of pre-ulcerative callus
b. History of previous foot ulceration	e. Foot Deformity
c. Peripheral neuropathy with evidence of callus formation	f. Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. Please state from the patient's medical record (or attach a copy), indicating the nature of the foot disorder that warrants the need for shoes. \_\_\_\_\_  
 \_\_\_\_\_

**Please check the diagnoses that apply**

<input type="checkbox"/> Neuroma of amputation stump 997.61	<input type="checkbox"/> Traumatic amputation of toe without complication 895.0	<input type="checkbox"/> Traumatic amputation of toe(s) with complication 895.1
<input type="checkbox"/> Corns and Callosities 700	<input type="checkbox"/> Bone Spur 726.91	<input type="checkbox"/> History of amputation of great toe V49.71
<input type="checkbox"/> Open wound of toe(s) without complication 893.0	<input type="checkbox"/> Open wound of toe(s) with complication 893.1	<input type="checkbox"/> History of amputation of other toe(s) V49.72
<input type="checkbox"/> Great toe angles toward other toes 735.0	<input type="checkbox"/> Great toe angles away from other toes 735.1	<input type="checkbox"/> Other acquired deformities of the toe 735.8
<input type="checkbox"/> Diabetes with peripheral circulatory disorders 250.7__ (specify fifth digit)		<input type="checkbox"/> Gangrene 785.4

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Physician's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Physician's Signature: \_\_\_\_\_ UPIN: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorized payment of medical benefits to \_\_\_\_\_ for services furnished. I further authorize the release of any medical information required to process Insurance claims on my behalf. I hereby permit a copy of this authorization to be valid as the original. I understand that all costs of devices and supplies not paid for by my insurance company will become my responsibility.

The footwear has been properly fitted with heat molded inserts and delivered to meet my needs and I have been given the Medicare Supplier Standards form.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 If unable to sign - Why?: \_\_\_\_\_ Caregiver - Authorized Signature: \_\_\_\_\_