DIVINE FOOTCARE CENTER INC.
117 Melbourne Rd., Hurst, TX 76053
Phone: **972-790-2800**
Fax: 972-790-2803
Email: **divinefootcarecenter@yahoo.com**

STATE OF CERTIFYING PHYSICIAN for THERAPUETIC SHOE and INSERTS

PATIENT NAME: _____ DOB: _____

I certify that all of the following statements are true:

1. The patient has Diabetes Mellitus- Please check one from each column:

☐ Uncontrolled	☐ Non-Insulin Dependent
☐ Controlled	☐ Insulin Dependent

2. The patient has one or more of the following conditions:
   - ☐ History of partial or complete amputation of foot
   - ☐ History of previous foot ulceration
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ History of pre-ulcerative callus
   - ☐ Foot deformity
   - ☐ Poor Circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. **Per Medicare Policy**, I discussed diabetic shoes/inserts with said patient on _____ (Date of Service) and **ATTACHED a signed progress note that confirms this appointment.**
5. Therapeutic Shoes (Extra Depth) and inserts are medical necessity because of his/her diabetic condition.

Physician's Name: _____
Phone: _____ **Fax:** _____
Address: _____
_____

Physicians Signature: _____ **Date:** _____

==========

DIVINE FOOTCARE CENTER INC.
117 Melbourne Rd., Hurst, TX 76053
Phone: **972-790-2800**
Fax: 972-790-2803
Email: **divinefootcarecenter@yahoo.com**

PRESCRIPTION FOR THERAPUETIC SHOES

PATIENT NAME: _____ DOB: _____
Primary Diagnosis: Diabetes Mellitus **ICD-10 CODE:** _____
Secondary Diagnosis (based on certifying statement): _____

Pertains to:			
	☐ Left Foot	☐ Right Foot	☐ Both Feet

Rx:

- ☐ Extra Depth Therapeutic Shoes (A5500)- One pair
- ☐ Custom Made shoes (A5501)- One Pair
- ☐ Custom Molded Diabetic Inserts (K0903)- Three Pairs
- ☐ Heat Moldable Diabetic Inserts (A5512)- Three Pairs
- ☐ Partial Foot Prosthetic insert (L5000)- One ☐Left ☐Right

Physician's Name: _____
Phone: _____ **Fax:** _____
Address: _____
_____

Physicians Signature: _____ **Date:** _____