STATEMENT OF CERTIFYING PHYSICIAN/DETAILED WRITTEN ORDER FOR THERAPEUTIC SHOES
(THIS FORM EXPIRES 6 MONTHS FROM THE SIGNATURE DATE)

PATIENT NAME: _____ DOB: _____

I certify that the following statements are true: **Health Insurance**: _____ **Auth needed see attached**

1: **This patient has Diabetes Mellitus (ICD-10) diagnosis code: _____**

2: **This patient has one or more of the following conditions: (*Circle all that apply*) ****PLEASE****

a: History of partial or complete amputation of the foot
b: History of previous foot ulceration
c: History of pre-ulcerative callus
d: Peripheral Neuropathy with evidence of callus formation
e: Foot deformity
f: Poor Circulation in either foot

3: **I am treating this patient under a comprehensive plan of care for his/her Diabetes.**

4: **This patient needs special shoes (depth) and inserts because of his/her Diabetes.**

With the Diabetic Footwear, the patient's prognosis is: _____

Physician Signature: ***_____*** **Date: _____**

(Must be signed by DPM Primary or Do)

I am prescribing: 1 pair of extra depth shoes Manufacturer: **Ped-Lite A5500** or **Apis A5501 special needs**

3 pairs of CUSTOM OR HEAT molded inserts Manufacturer: **Ped-Lite A5513**

Toe Filler or Modifications: _____ Right: _____ Left: _____ Manufacturer: **Apis L 5000**

Amputation Diagnosis: _____

Physician Signature: ***_____*** **Date: _____**

(MUST BE SIGNED BY PRIMARY DOCTOR's ONLY)

Please send Insurance Cards and last office notes

Print Physician Name: _____

NPI#: _____ **Physician Address: _____**

_____

PLEASE FAX TO: AMERICAN ORTHOPAEDICS & DIABETIC SHOES AT: 1-888-537-3611 OR CALL

239-541-9480 WITH QUESTIONS. 621 Cape Coral Pkwy E. Suite # 1 Cape Coral, FL 33904