

DIABETIC CERTIFICATION AND PRESCRIPTION

Patient's Name: _____

Address: _____

City: _____ State _____ Zip _____

Date of Birth: _____ Phone _____

I authorize the release of any information necessary to process this claim and request that payment of all government or private benefits be made to myself or to the party who accepts assignments for the services listed below. In addition, my signature indicates that I received all services as prescribed by my physician. I understand, should my insurance not make appropriate payment nor cover items dispersed, I will be personally responsible for payment.

Signature of patient or guardian: _____

Date: _____

*1 The patient has diabetes mellitus

*2 The patient has at least one of the following:

- a. Poor circulation of either foot
- b. Foot deformity of either foot (bunions, hammer toes, etc)
- c. Peripheral neuropathy with callus formation on either foot
- d. History of previous pre-ulcerative calluses
- e. History of previous foot ulceration
- f. Previous amputation of part of either foot

*3 Therapeutic shoes are part of a comprehensive plan in treating the patient

Patient is insulin dependent _____ Non-insulin dependent _____

PRESCRIPTION

_____ Extra depth footwear with diabetic inserts

_____ Modifications or other instructions _____

Prescribing Physician: (signature) _____ MD or DO only

(print name) _____ Date _____

Physician's UPIN# _____ ICD-9 CODES _____ (ICD-9 Diagnosis Codes 250.00-250.91)

Shoes 'n Stuff • 2133 Rockford Street • Suite 500 • Mount Airy, NC 27030
Phone: (336) 789-8494 • Fax: (336) 789-8561 • shoesandstuff@earthlink.net
Ronnie Kirkman, Board Certified Pedorthist