

# 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)

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**Ronnie Kirkman, Board Certified Pedorthist**