

DIABETIC CERTIFICATION AND FOOTWEAR PRESCRIPTION

Patient's Name _____ Date of Birth _____

HIC# _____ Phone Number _____

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 (bunions, hammer toes, pes planus, pes cavus, etc.)
 - _____ c. Peripheral neuropathy with callus formation on either foot
 - _____ d. History of pre-ulcerative calluses
 - _____ e. History of previous foot ulceration
 - _____ f. Previous amputation of part of either foot
3. I conducted a foot evaluation on this date and noted **at least one of the above conditions in the patient's file. **Doctor, please note that if this is not documented in the patient's file Medicare will not pay.**
4. I am treating this patient under a comprehensive plan of care for his/her diabetes.
5. The patient needs special shoes (depth or custom molded with appropriate inserts) because of his/her diabetes.

Physician Signature _____ Date of Foot Exam _____

_____ NPI: _____
Physician Name (printed – **must be an M.D. or D.O.** per Medicare requirements)

Physician Address _____

Prescription

_____ A5500 Extra depth footwear (1 pair) _____ A5512 Heat Molded Inserts (3 pairs) _____ A5513 Custom Inserts (3 pairs)

_____ Modifications or other instructions _____

Physician Signature _____ Date _____

This form must be accompanied by the patient's chart notes signed by an MD or DO documenting the existence of at least one of the qualifying conditions (per Medicare).

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