

## THERAPEUTIC FOOTWEAR ORDER FORM

121 St. Nicholas Ave Brooklyn, NY 11237 TEL: 718-381-5116 FAX: 718-417-3621

NEW PATIENT	CURRENT PATIENT

Today's Date

Proudly serving over 30 years

& WEDICKE SCITEIES	ribudiy serving over 50 years	
		the DMEPOS Supplier) may provide them with therapeutic shoes and
		r Medicare guidelines (excerpt bolded below from Cigna Government
ervices), in the event of an audit for this particular patient's claim fo	or therapeutic shoes and inserts:	

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed below is present. When requested by the supplier, you must provide copies of those records. If you would not be able to meet such a request, please contact us prior to completing this form. We greatly appreciate your assistance in providing for this patient!

	please confact us prior to comp st Name				-	Weiaht	Male Female				
Daytime Tel	Evening Tel	Cell ,	970	Email							
Ship to Patient at	☐ Home ☐ Work <b>OR</b>	Patient will pick up at	Physician (	Office Pharmac	y Date	Needed					
The patient above	e has diabetes mellitus (ICI	)-9 Code)		(250.0	0 – 250.91)						
Insured's Name_		Relation to Po	atient	Eligible fo	r Medicare	Yes No If yes, N	Лedicare#				
Prescription Card	Yes No If Yes, Carri	erTel_		Fax		Policy/Group#					
Bin#	Pcn	‡	RXIC	D#	RX Gr	oup#					
Prescriber's Name				Office Contact _							
Street Address			Suite #	City		State	Zip				
Tel	Fax	Emai									
License#	NPI#		UPIN	N#		DEA#					
STATEMEN	IT OF CERTIFYII	NG PHYSICIAI	٧				NSURANCE CARDS, MEMBER ID NUMBER				
	following statements are to es (depth or custom mold				n of care for	diabetes. This patient	will benefit from				
The patient has	one or more of the followir	ng. (Please check all that	apply)	By signing below, I							
☐ History of partial or complete amputation of either foot			<ol> <li>I am or was this patients treating physician for diabetic mellitus on the effective date of this order.</li> <li>This order accurately reflects this patient's diagnosis and condition.</li> <li>The patient's diagnosis, condition and the ordering of diabetic shoes and inserts are substantiated in my medical records.         (Please Fax These Records With This Order)     </li> <li>This order is part of my course of treatment and is "reasonably and</li> </ol>								
Peripheral Neuropathy with evidence of callus formation of either foot											
<ul> <li>History of previous foot ulceration</li> <li>Foot deformity of either foot (bunions, hammer toes, etc.)</li> <li>History of pre-ulcerative callus formation</li> <li>Poor circulation in either foot</li> </ul>											
								medically necessary". 5. To my knowledge, the above information is accurate.			
								Prescriber's Sign	<b>ature</b> (signature required. NC	) STAMPS)	

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