

# Diabetic Shoes Order Form & Statement of Certifying Physician

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ADDRESS: 5504 13TH AVE BROOKLYN, NY 11219

1. This form must be completed BY THE **PHYSICIAN TREATING THE PATIENT FOR DIABETES**
2. The **PHYSICIAN TREATING THE PATIENT FOR DIABETES** must provide clinical notes documenting the patient's diabetes management and the medical necessity for diabetic shoes
3. A prescription from the Physician treating the diabetes **OR** Podiatrist is required, specifying:
  - a. Diabetic Depth Inlay Shoes (1 pair allowed/year)

**AND**

  - b. Heat Molded Multiple Density Inserts (max 3 pairs allowed/year)

## PATIENT INFORMATION

FIRST NAME:

LAST NAME:

DOB:

GENDER:

HT:

WT:

ADDRESS:

CITY:

STATE:

ZIP:

HOME PHONE:

CELL PHONE:

E-MAIL:

EMERGENCY CONTACT:

RELATION:

PHONE:

## INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

SECONDARY INSURANCE NAME:

PRIMARY INSURANCE ID:

SECONDARY INSURANCE ID:

MEDICAID ID:

## SHOE & INSERT ORDER (specify quantity)

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Diabetic Depth Inlay Shoes

Quantity: \_\_\_\_\_ (max 1 pair/year)

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Heat Molded Multiple Density Inserts

Quantity: \_\_\_\_\_ (max 3 pair/year)

PHYSICIAN NAME:

NPI:

PHYSICIAN SIGNATURE:

Date:

## STATEMENT OF CERTIFYING PHYSICIAN (select all that apply)

### 1. PATIENT HAS DIABETES MELLITUS

Diagnosis Code for Diabetes (ICD-10): \_\_\_\_\_

- I am treating this patient under a comprehensive plan of care for their diabetes
- Patient needs special shoes and/or inserts because of their diabetes
- Date of last in-person visit that addressed patient's diabetes management: \_\_\_\_\_

### 2. PATIENT HAS 1 OR MORE OF THE FOLLOWING CONDITION(S):

Diagnosis Code for Foot condition (ICD-10): \_\_\_\_\_

(select all that apply)

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History of partial or complete amputation of the foot

☐

Foot deformity

☐

History of pre-ulcerative callus formation

☐

Poor circulation

☐

Peripheral neuropathy with evidence of callus formation

☐

History of previous foot ulceration

## CERTIFICATE OF MEDICAL NECESSITY

I certify that the clinical information provided above is true and accurate to the best of my knowledge and the items ordered above are medically necessary for my patient. By signing below, I attest that I have no financial relationship with the DME supplier.

Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*FAX FORM TO 718-436-3649 OR SEND ELECTRONIC PRESCRIPTION DIRECTLY FROM YOUR EMR SYSTEM OR FROM PARACHUTE HEALTH\*\*\*