Statement of Medical Necessity

Statement of certifying physician for therapeutic shoes.

Patient Name: ____

Social Security #: ____

1.) I certify that all of the following statements are true:

____ 250.00 ____ 250.01 ____ 250.02

____ 250.03 ____other

2.) This patient has one or more of the following conditions:

____ Previous amputation of the foot or part of the foot

____ History of previous foot ulceration

____ Pre-ulcerative callus formation of peripheral neuropathy with a history of callus formation

____ Foot deformity

____ Poor circulation

3.) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4.) This patient needs extra depth shoes with inserts because of his/her diabetes.

# UNITS	HCPCS CODE	PRESCRIPTION
1 2	A5500	Extra-depth shoes
2 4 6	A5512	Heat Moldable insert
2 4 6	A5513	Custom insert

Physician Signature: ______________________Date: ___________

Physician Name (print): _______________________________________

NPI #: _______________________________________

Primary Care Office Address: __________________________________

____

PRESCRIPTION OF THERAPEUTIC SHOES

Patient Name: ____

HIC#: ____

Date: ____

Age: __________ Phone #: ___________________

Address: ____

____

Per Statement of Certifying Physician, the patient has one or more of the following foot conditions:

____ Previous Amputation

____ Foot Deformity

____ Poor Circulation

____ Peripheral Neuropathy

____ Previous Ulceration

____ Pre Ulcerative Callus

Shoe Prescribed: ____ Extra Depth

Insert Prescribed: ____ Heat Molded ____ Custom Fabricated

Instruction: ____

____

NPI#: ____________________ Date: ____________________

Physician Name: ____

Physician Signature:____