Pro Medical East LLC
A GARDEN STATE MEDICAL SUPPLY COMPANY

PHYSICIAN ORDER AND CERTIFYING PHYSICIAN STATEMENT FOR DIABETIC SHOES AND INSERTS

PATIENT INFORMATION

NAME _____ ADDRESS _____ CITY _____ STATE ___ ZIP _____

INSURANCE _____ NUMBER _____ PHONE _____ SEX ___ DOB _____

PHYSICIAN INFORMATION

PHYSICIAN _____ NPI# _____ FAX _____

ADDRESS _____ CITY, STATE, ZIP _____ PHONE _____

APPROVED SERVICES

All information must be filled out completely and reviewed by physician

Required. 1 pair unless otherwise noted

☐ **A5500** Extra Depth Diabetic Shoes

Required. Choose One. 3 Pair unless otherwise noted.

☐ **Custom** Molded Inserts ☐ **Heat** Molded Inserts

Optional

☐ **L5000** PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER ☐ LEFT ☐ RIGHT

SECTIONS A & B MUST BE COMPLETED FOR PRESCRIPTION TO BE VALID

SECTION A - PRIMARY DIAGNOSIS

Required. Choose One. DIABETES MELLITUS (Please fill in correct ICD-10 code)

TYPE I
W/ DIABETIC NEUROPATHY ☐ E10.40
W/O COMPLICATIONS ☐ E10.9

TYPE II
W/ DIABETIC NEUROPATHY ☐ E11.40
W/O COMPLICATIONS ☐ E11.9

OTHER _____

SECTION B - SECONDARY DIAGNOSIS

Requred. Choose at least 1.

I further determined that the patient has one or more of the following conditions: (Check all that apply and fill in ICD-10 code)

HISTORY OF PREVIOUS FOOT ULCERATION
☐ Z86.31

HISTORY OF PRE-ULCERATIVE CALLUS
☐ L84

POOR CIRCULATION
☐ I87.2

OTHER _____

HISTORY OF PARTIAL OR COMPLETE AMPUTATION OF THE FOOT

FOOT
LT ☐ Z89.432 RT ☐ Z89.431

ANKLE
LT ☐ Z89.442 RT ☐ Z89.441

GREAT TOE
LT ☐ Z89.412 RT ☐ Z89.411

OTHER TOE(S)
LT ☐ Z89.422 RT ☐ Z89.421

FOOT DEFORMITY

HAMMERTOES
LT ☐ M20.42 RT ☐ M20.41

BUNIONS
LT ☐ M20.12 RT ☐ M20.11

HEEL SPURS
LT ☐ M77. 32 RT ☐ M77. 31

OTHER _____

PHYSICIAN SIGNATURE AND PHYSICIAN INFORMATION MUST MATCH FOR PRESCRIPTION TO BE VALID
SIGNATURE STAMPS ARE NOT ACCEPTABLE

I certify that I or an NP/PA on my staff am treating this patient under a comprehensive plan of care for their diabetes. I certify that the information provided is true and correct and that I have thoroughly documented **and/or approved** the patient's medical necessity for the product(s) ordered. I will provide all required supporting documentation to Pro Medical East upon request.

MD OR DO, PECOS ENROLLED ONLY
PHYSICIAN SIGNATURE _____ DATE _____

PLEASE FAX PRESCRIPTION TO 603-835-3229

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