Foothills Prosthetics

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Prescription/Letter of Medical Necessity for Therapeutic Shoes/Inserts

Patient: _____ Date of Birth: _____

I certify that all of the following statements are true:

1) The patient has diabetes mellitus.

- ☐ E11.9 NIDDM
- ☐ E10.9 IDDM
- ☐ E11.65 NIDDM, uncontrolled
- ☐ E10.65 IDDM, uncontrolled

2) This patient has one or more of the following conditions (please circle applicable items):

- ☐ History of partial or complete amputation of the foot.
- ☐ History of previous foot ulceration.
- ☐ History of pre-ulcerative callus.
- ☐ Peripheral neuropathy with evidence 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 prescription diabetic shoes and inserts because of his/her diabetes.

I certify active treatment of this patient. This equipment is part of my course of treatment and is "reasonably and medically necessary", and is not a convenience item. To my knowledge, the above information is accurate.

Physician Signature: _____Date:_____

Physician name: _____ NPI: _____
Printed, must be MD or DO