Diabetic Shoes Form

Patient Name:_____
D.O.B._____ **Gender: M / F**
Address:_____ **City**:_____ **State:**_____
Zip: _____**Phone**: _____
Medicare#:_____ **Medicaid#**:_____ **SSN**: _____
Other Insurance: _____

1. The patient has Diabetes Mellitus: Y / N

2. **The patient has one or more of the following foot conditions**: ***(check all that apply)***
   - ☐ Previous amputation of the other foot, or part of either the foot (ICD-10) _____
   - ☐ History of previous foot ulceration of either foot (ICD-10) _____
   - ☐ History of pre-ulcerative calluses of either foot (ICD-10) _____
   - ☐ Peripheral neuropathy with evidence of callus formation of either foot (ICD-10) _____
   - ☐ Foot deformity of either foot (ICD-10) _____
   - ☐ Poor circulation in either foot (ICD-10) _____

Physician's Prescription

The patient needs ___Extra depth ____ Custom Shoes (*Check one*)
☐ 1 pair of diabetic shoes (A5500) with 3 pairs heat molded inserts (A5512)
☐ 1 pair of diabetic shoes (A5500) with 3 pairs of custom inserts (A5513)
☐ 1 pair of diabetic shoes (A5500) with
3 diabetic custom inserts (A5513) ___RT___LT with 1 toe filler (L5000) ___RT ___LT
☐ 1 pair of diabetic shoes (A5500) and bilateral toe filler (L5000)
☐ 1 pair of diabetic custom shoes (A5501) with 3 pairs of custom inserts (A5513)
☐ AFO ___RT __LT
☐ Thermal Gauntlets ___RT ___LT
☐ Other: _____

_____ _____
(Physicians Name) (Physicians Signature)

_____ _____
(Physician's NPI) (Date)