HILL COUNTRY
Orthotics & Prosthetics

Diabetic Shoes & Inserts Order

PHONE: (210) 614-8777 • FAX: (210) 694-4581

WELLMED INSURANCE? ☐ YES ☐ NO

CLEAR FORM

• Patient Information (Provided separately? ☐ YES ☐ NO)

Name | DOB | Phone Number 1 | Phone Number 2

Address Line 1 | City | State | ZIP | Sex

Primary Insurance Provider | Member ID # | Relationship to Subscriber

Secondary Insurance Provider | Member ID # | Relationship to Subscriber

Physician Information

Name | Credentials | Phone Number | Fax Number

NPI | Address Line 1 | City | State | ZIP

Name | Credentials | Phone Number | Fax Number

NPI | Address Line 1 | City | State | ZIP

1) Prescription

Diabetic ICD-10(s) | Description(s)

Foot Condition ICD-10(s) | Description(s)

ITEMS NEEDED: (CHANGE SELECTION)

LENGTH OF NEED:

- ☐ Diabetic Shoes A5500 x2 with **Heat Moldable Inserts** A5512 x6
- ☐ Diabetic Shoes A5500 x2 with **Custom Inserts** A5513/A5514 x6
- ☐ Diabetic Shoes A5500 x2 with **(select one):**
  - ☐ **Right Side Toe Filler** L5000 x1 and Left Side Diabetic Inserts, Custom A5513/A5514 x3
  - ☐ **Left Side Toe Filler** L5000 x1 and Right Side Diabetic Inserts, Custom A5513/A5514 x3
  - ☐ **Bilateral Toe Fillers** L5000 x2
- ☐ Diabetic Custom Shoes A5501 x2 with Custom Inserts A5513/A5514 x6
- ☐ Other Items (specify): _____

The above procedures/devices are appropriate for this patient and are deemed medically necessary.

Signature | Name | Credentials | NPI | Date

STOP HERE if you are not the MD or DO treating this patient for their diabetic condition.
PLEASE REFER this patient to their MD or DO to comply with insurance requirements: HillCountryOandP.com/FootExamReferral

2) Statement of Certifying Physician (MD or DO only)

1) This patient has diabetes mellitus.
2) This patient has the following conditions **(select all that apply)**:

- ☐ 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 special shoes (depth or custom-molded shoes) because of his/her diabetes.
5) I have seen this patient for diabetes management within the last 6 months. I understand that the shoes must be delivered **within 3 months** of the signature date on this form AND with 6 months of the last in-person physician visit.
6) The above procedures/devices are appropriate for this patient and are deemed medically necessary.

Signature | Name | ☐ MD ☐ DO | NPI | Date

3) ☐ Progress Notes from Diabetes Management Visit & Foot Exam included with order (MD or DO only)

Guidelines for performing a diabetic foot exam can be found here: HillCountryOandP.com/FootExam