Priority
Footwear and Pedorthic Services
Health - Comfort - Compassion

Form 1 of 2
PLEASE FAX TO: 503-524-8397

Medicare Certification Statement for Therapeutic Footwear

The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician.

Patient Name:_____ Date of Birth:_____

Address:_____
(City) (State) (Zip Code)

Phone Number:_____ Medicare HICN:_____

I certify that all of the following statements are true:
I am treating this patient under a comprehensive plan of care for his/her diabetes. This equipment is part of my course of treatment and is "reasonably and medically necessary". This patient needs special shoes (depth or custom-molded) and inserts because of their diabetic condition.

This Patient Has Diabetes Mellitus. (List ICD-10 Codes): _____
(Applicable ICD-10 Range E08.00-E13.90)

This Patient Has One or More of the Following Conditions. (Check all that apply).

- ☐ History of Partial or Complete Foot Amputation
- ☐ Peripheral Neuropathy w/ Evidence of Callus
- ☐ Poor Circulation
- ☐ History of Pre-Ulcerative Callus
- ☐ Foot Deformity (Bunion, Hammertoe, Corns)
- ☐ Previous Ulcer(s)

MD/DO only per medicare requirements no co-signatures

Certifying Physician Information: Name (printed):_____

Signature:_____ Date:__/__/__ NPI:_____
Medicare does not allow co-signatures

Address:_____
(City) (State) (Zip Code)

Phone:_____Fax:_____

Prescription Order for Therapeutic Footwear

Prescribing Physician may be an M.D., D.O. or D.P.M. and may be different from certifying physician

Diagnosis: Diabetes w/ complications Purpose: To protect feet, facilitate ambulation and improve circulation
RX:

_X_ Extra Depth Shoes (A5500), w/ 3 Pair Diabetic Custom Inserts (A5513/A5514)

___ Toe Filler Orthotics (L5000)

MD/DO or DPM only per medicare requirements no co-signatures

Prescribing Physician Information:

Signature:_____ Date Signed:_____
Medicare does not allow co-signatures

Name (printed):_____ NPI:_____

This prescription is giving provider authority to dispense prescribed items.

Please send form to: Priority Footwear & Pedorthic Services
10240 SW Nimbus Ave, Suite L1, Portland, OR 97223 - Phone: 503-524-9656 Fax: 503-524-8397

Priority
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Form 2 of 2
PLEASE FAX TO: 503-524-8397

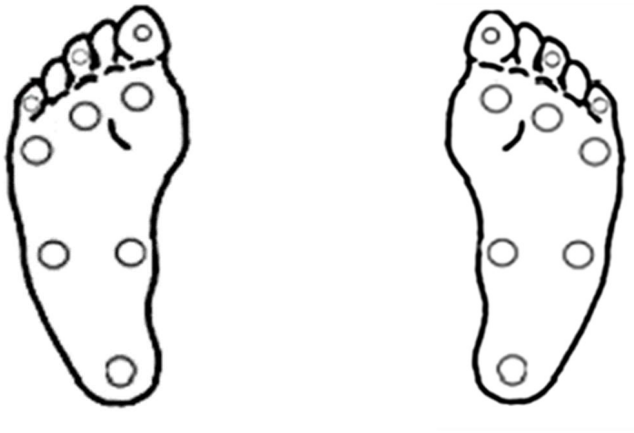
Physician Notes on Qualifying Conditions for Therapeutic Footwear

The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician.

Patient Name:_____ Date of Birth:_____
Physician Name:_____ Date of Exam:_____

Indicate the level of sensation in the circles on the foot diagram.

10-g Semmes-Weinstein 5.07 Monofilament Test
+ = sensation present
- = sensation absent
! = sensation diminished



Left Right

Indicate qualifying condition(s) below by checking appropriate box(es).

Physical Exam:

	Left	Right	No
Previous Amputation	☐ 1 2 3 4 5 TM	☐ 1 2 3 4 5 TM	☐
Current Foot Ulcer(s)	☐	☐	☐
History of Foot Ulcer(s)	☐	☐	☐
Toe Deformity (Bunion, etc.)	☐ 1 2 3 4 5	☐ 1 2 3 4 5	☐
Abnormal Foot Shape	☐	☐	☐
Evidence of Callus	☐	☐	☐
History of Pre-Ulcerative Callus	☐	☐	☐
Edema	☐	☐	☐
Blister /Laceration	☐	☐	☐

Vascular Exam:

	Left	Right
Dorsalis Pedis	Y ☐ N ☐	Y ☐ N ☐
Posterior Tibial	Y ☐ N ☐	Y ☐ N ☐
Capillary Refill	0-5 5+	0-5 5+

Vascular findings constitute poor circulation to lower extremities.
YES ☐ NO ☐

Certifying Physician Acknowledgement:
I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. Part of my comprehensive plan of care includes therapeutic footwear.

Certifying Physician Name: (printed):_____

Signature:_____ Date:___/___/___ NPI:_____
Medicare does not allow co-signatures

MD/DO only per Medicare requirements no co-signatures