Priority
Footwear and Pedorthic Services
Health - Comfort - Compassion

Form 1 of 1
PLEASE FAX TO: (503) 524-8397

Non-Medicare Certification Statement for Therapeutic Footwear

The certifying physician may be the A.R.N.P, P.A., 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: _____ Insurance ID: _____

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 E8.00-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)

Certifying Physician Information**:** Name (printed):_____

Signature:_____ Date:____/___/_____NPI:_____

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

Phone: _____

Prescription Order for Therapeutic Footwear

Prescribing Physician may be an A.R.N.P, P.A., 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:

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

___ Toe Filler Orthotics (L5000)

☑ Night Time Gauntlets (L1902)

Prescribing Physician Information:

Signature:_____ Date Signed:_____

Name (printed): _____ NPI: _____

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