Diabetic Footwear & Supply

7036 W. Palmetto Park Road • Boca Raton, FL 33433
PHONE (561) 338-3838 • FAX (561) 338-5318

PAUL WEINER, *Licensed & Certified Pedorthist*

Please have the following paperwork completed for your diabetic shoes.

1. **ATTACHED DIABETIC SHOE BILL FORM COMPLETED BY YOUR MD I.E. YOUR ENDOCRINOLOGIST OR INTERNIST, NOT YOUR PODIATRIST.**
2. **A SEPARATE PRESCRIPTION FOR: "1 PAIR OF DEPTH SHOES" COMPLETED BY YOUR MD OR PODIATRIST.**
3. **MEDICARE REQUIRES THE MD/PODIATRIST TO PROVIDE THEIR OFFICE PROGRESS NOTES. THE NOTES MUST CLEARLY AND SPECIFICALLY SUPPORT THE CONDITION IDENTIFIED ON THE RX.**

ONCE YOU HAVE THE PROGRESS NOTES, DIABETIC SHOE FORM AND THE PRESCRIPTION COMPLETED,

KINDLY CALL OUR STORE AT (561) 338-3838 TO SET UP AN APPOINTMENT.

Please be advised that you are responsible for any deductible. You will be billed for any charges not covered by your Medicare and secondary insurance.

Finally, the Diabetic Footwear program is not covered under any Health Maintenance Organization (HMO) or Medicare Complete Program.

Sincerely yours,
Paul Weiner

PRESIDENT

Rev. 3/16

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@Walk'n Shoes

SINCE 1987

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STATEMENT OF CERTIFYING PHYSICIANS FOR THERAPEUTIC SHOES

Patient: _____

HIC # _____ Order Date: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus:
   ICD-10 diagnosis codes ☐ E11.9 ☐ E10.9 ☐ Other_____
2. **The patient has one or more of the following conditions.**
   - **(a) History of partial or complete amputation of the foot**
   - **(b) History of previous foot ulcerations**
   - **(c) History of pre-ulcerative callus**
   - **(d) Peripheral neuropathy with evidence of callus formation - must have both**
   - **(e) Foot deformity**
   - **(f) Poor circulation in pedal pulses**
3. **Progress notes that support patient's condition #1 & #2 must be included.**
4. I am treating this patient under a comprehensive plan of care for his/her diabetes.
5. **This patient needs 1 pair of Depth shoes and 3 pair of diabetic direct mold inserts because of his/her diabetes.**
6. **I certifiy that all the preceding indicated statements are true.**

Physician's Signature:_____ **Start Date:** _____
(Must be MD or DO)

Address: _____

Physician's Name (printed):_____

Physician's Phone: (W)_____**(F)** _____

PROGRESS NOTES MUST CONTAIN THE CONDITIONS STATED IN #1 AND #2 OF THIS STATEMENT. IF NOT INCLUDED, PATIENT IS UNABLE TO RECEIVE DIABETIC SHOES. ***SORRY FOR ANY INCONVENIENCE.***

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THIS FORM MUST BE COMPLETED BY A PRESCRIBING PHYSICIAN WHO MANAGES THE CARE OF THE PATIENT'S FEET.

Patient's Name: _____ Order Date _____

Patient's D.O.B. _____

DX

_____ Previous Amputation _____ Foot Deformity

_____ Previous Ulceration _____ Peripheral Neuropathy

_____ Pre-ulcer Callus _____ Poor Circulation

RX

☐ Extra Depth Shoes (A5500) – (2 Shoes)

☐ Direct Mold Inserts (A5512) – (3 Pair of Diabetic Direct Mold Inserts)

Other instructions: _____

_____

_____

Please provide progress notes that supports patient's condition

Physician's Signature:_____ **Start Date:**_____

(Must be an MD, DO or DPM)

Address: _____

Physician's Name (printed):_____

Physician's Phone: (W)_____**(F)** _____