**George Allen Shoes** 13003 S Western Ave. Blue Island, IL 60406 708.388.8570 phone 708.824.2606 fax

Name\_

## **DIABETIC CERTIFICATION** FOR THERAPEUTIC FOOTWEAR

ATTENTION DD.

**MUST COMPLETE ALL 4 STEPS++	ATTENTION DR.
T4 SIEPS**	Date

Address			City	State	Zip Code
Date of Birth	_	_HIC#		Telephone	
1			<b>— —</b>		
MARK (	<u>)NE</u> : ICD-10	diagnosis code	<b>E11.9 E1</b>	<b>0.8 LE11.65 LE10</b> nas diabetes mellitus)	<u>.9</u> or Other:
_/_			(The patient)	itas aitasetes ineintas,	,
		THE ITEM(S) . LAIM WILL BI		ST BE DOCUMENT	ED IN THE PATIENT
	ulation of eith		E DENIED.	☐ History of pre	-ulcerative calluses
	Foot deformity of either foot (bunions,		History of previous foot ulceration		vious foot ulceration
hammer toes,				☐ Previous amp	utation of part of either
	I neuropathy w	ith callus form	atıon		
on either foot !! Therapeutic	shoes are a na	rt of a compreh	ensive plan of a	care in treating the pa	tient
	i. Chart notes i	nust be availabl	le for foot condi	tion and diabetes wh	en ordering this product
<b>k</b>	i: Chart hotes i	nust be availabl	le for foot condi	tion and diabetes wh	en ordering this product
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SIGN # PHYSICIAN	<u>1</u>			M.D. or D.O. only p	en ordering this product er Medicare Requirements Г OR TYPE YOUR
PHYSICIAN	<u>1</u>	GNATURE IS		M.D. or D.O. only p	er Medicare Requirements
PHYSICIAN NAME AND	<u>1</u> . , IF YOUR SI INITIAL IT I	GNATURE IS	NOT LEGIBI	M.D. or D.O. only p LE, PLEASE PRIN	er Medicare Requirements
PHYSICIAN NAME AND Print name	1. , IF YOUR SI INITIAL IT	GNATURE IS BELOW.	S NOT LEGIBI	M.D. or D.O. only p LE, PLEASE PRIN' Phone	er Medicare Requirements FOR TYPE YOUR
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