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

DIABETIC CERTIFICATION
FOR THERAPEUTIC FOOTWEAR

****MUST COMPLETE ALL 4 STEPS****

ATTENTION DR:

Name_____ Date _____

Address_____**City**_____**State**___**Zip Code**_____

Date of Birth_____ **HIC#**_____ **Telephone**_____

Step 1 **MARK ONE: ICD-10 diagnosis code** ☐**E11.9** ☐**E10.8** ☐**E11.65** ☐**E10.9** or Other:_____
(The patient has diabetes mellitus)

Step 2 **MARK ONE:** or more THE ITEM(S) MARKED MUST BE DOCUMENTED IN THE PATIENT'S RECORDS OR THE CLAIM WILL BE DENIED**.**

☐ Poor circulation of either foot
☐ Foot deformity of either foot (bunions, hammer toes, etc.)
☐ Peripheral neuropathy with callus formation on either foot
☐ History of pre-ulcerative calluses
☐ History of previous foot ulceration
☐ Previous amputation of part of either foot

!! Therapeutic shoes are a part of a comprehensive plan of care in treating the patient.
!! Verification: Chart notes must be available for foot condition and diabetes when ordering this product.

Step 3 **SIGN #1**._____ **M.D. or D.O. only per Medicare Requirements**
PHYSICIAN, IF YOUR SIGNATURE IS NOT LEGIBLE, PLEASE PRINT OR TYPE YOUR NAME AND INITIAL IT BELOW.

Print name _____ **Phone** _____

Address _____ **Fax** _____

City _____State ____ Zip _____ **NPI#**_____

*****THESE ARE 2 SEPARATE FORMS AND MUST BE FILLED OUT ENTIRELY*****

Prescription form for Therapeutic Footwear: Depth shoes and Inserts
Patient Name_____**DOB:**_____

Step 4 **Dr Sign #2** _____**NPI:**_____

The Patient Requires: _X_ Diabetic Footwear (A5500) 1 pair (unless otherwise indicated)
_X_ Custom molded inserts (A5513) or Non custom, heat moldable inserts (A5512) 3 (pairs unless otherwise indicated)
__ Custom Toe Filler (L5000) Left and or Right
__ Additional mods or Instructions _____

PLEASE COMPLETE AND FAX TO 708.824.2606