Diabetic Soles

DETAILED WRITTEN ORDER

Office Phone: (678)-919-9128

Fax This Form To: (888)-495-8205

DiabeticSoles.com

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Insurance: _____ ID#: _____ Deductible: _____

I authorize Diabetic Soles to access my physician's certification of medical need to verify my qualifications of medical supplies. Diabetic Soles may access and retain a copy of my medical records and other pertinent data which may be necessary for delivery of services.

Patient's Signature: _____ Date: _____/_____/_____ Referred By: _____

(RX): FOR PHYSICIAN TO COMPLETE

☐ **A5500 DIABETIC SHOES** (2 units) ☐ **A5512 / A5513 INSOLES** (6 units) ☐ **L1902 AFG** (2 units)

☐ **A5501 CUSTOM SHOE** (___ units) ☐ **L5000 TOE FILLER** ☐**Left** ☐**Right**

ICD-10 Codes: _____ (E11.9 – E11.65)

The patient has one or more of the following foot conditions:

___Partial/complete amputation of foot ___Foot deformity

___Peripheral neuropathy; evidence of callus formation ___History of previous foot ulceration

___History of pre-ulcerative callus ___Poor circulation

MEASUREMENTS

Shoe Style:

Product #:

Color:

Size / Width:

☐ **LUMBAR SUPPORT (L0650 / L0648 / L0631)**
Size: _____

_____ M51.26, M51.27 Lumbar Disc Displacement
_____ M54.5 Lumbago (low back pain)
_____ M54.16 Radiculopathy Lumbar Region

☐ **Replacement Brace (see attachment for explanation)**

☐ **OPEN WRAP KNEE BRACE (L1832 / L1833)**
Left size: _____ **Right size:** _____

_____ M17.0, M17.11(***R***) M17.12 (***L***) Osteoarthritis
_____ M06.9, M05.86 Rheumatoid Arthritis
_____ S83.219A, S83.509A Dislocation of knee

☐ **Replacement Brace (see attachment for explanation)**

☐ **CARPAL TUNNEL GLOVE (L3809)**
Left size: _____ **Right size:** _____

_____ G56.01(***R***) G56.02(***L***)G56.03(***Bilateral***)CarpalTunnel
_____ M19.041(***R***), M19.042 (***L***) Osteoarthritis of hand

☐ **ANKLE FOOT ORTHOSIS (L1940, L2330, L2820/L1971/L1951)**
Left size:_____ **Right size:** _____ **Bilateral:** _____

_____ R26.81 Unsteadiness On Feet
_____ Other: _____

PHYSICIAN'S CERTIFYING SIGNATURE

By my signature, I certify that: (1) I am treating this patient under a comprehensive plan of care. (2) I have evaluated their medical conditions and need for the DME items checked above (including replacement equipment). (3) I approve these items and certify that the information provided is true and correct, to the best of my knowledge.

√_____ √_____

Physicians Signature Date

_____ _____

Physicians Name (Printed) Physician's NPI

_____ _____

Physician's Phone Physician's Fax

Physician's Address: _____