KINETIC O&P LTD.

DIABETIC FOOTWEAR PRESCRIPTION FORM

Patient Name:_____ DOB: _____ HIC#_____

This patient has diabetes mellitus ICD-10 _____ **and** one or more of the following conditions. ***{CHECK ALL THAT APPLY}:***

___Peripheral neuropathy
___History of previous foot ulceration
___History of pre-ulcerative callus
___History of partial or complete amputation of the foot
___Foot deformity
___Poor circulation

Covered Procedures:

___Depth Shoes (A5500) indicate inserts below
___Customized inserts (heat molded prefab-average life is 4 months/pair (A5512)
# of pairs 1 2 3 (Medicare allows up to 3 pairs)
___Custom Inserts (A5513) Average life is 4 months/pair
# of pairs 1 2 3 (Medicare allows up to 3 pairs)
___Custom Toe Filler (L5000) Left Right
# of units per foot; 1 2 3
___Custom Molded Shoes (A5501) and total of 3 pairs of custom inserts (A5513) Average life 4 months
___Rigid Rocker Bottom Sole or Bar (A5503)
___Sole/Heel Wedge (A5504)
___Metatarsal Bar (A5505)
___Other modifications (Medial stabilizers, Lateral stabilizers, etc) (A5507)

Rx.Instructions: _____

PRESCRIBING PHYSICIAN INFORMATION:

Physician signature: _____ Date Signed:_____

Physician name printed: _____

Physician address: _____

Physician NPI: _____

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