PROPER FIT DIABETIC SHOES

10639 BURBANK BLVD, NORTH HOLLYWOOD, CA 91601
TEL: 818-980-1927 FAX: 818-980-1928

PATIENT AUTHORIZATION FORM

Patient Name: First ____________________ Middle ___________ Last ______________________

DOB: ____/____/____ Gender: ☐ Male ☐ Female

Address: ____ City: ______________________

State: _____ Zip: _________ Phone: ______________________ Alt. Phone: ____________________

Primary Insurance: ___________________________ Secondary Insurance: _______________________

Policy# ___________________________________ Policy# _______________________________

I authorize the supplier to get my physician's approval, prescription and certification of medical need, and to contact my insurance provider to verify the qualifications for benefits under the Diabetic and Therapeutic Shoe Bill. Supplier may access and retain a copy of my medical records in conjunction with the evaluation of my diabetes and pre-existing foot conditions, medication and other pertinent information that is necessary for delivery of services, record keeping, regulatory documentation and billing.

Patient Signature: ____ Date: _____/_____/_____

If signed by another person, please print the name and relationship next to the signature.

Statement of Certifying Physician for Diabetic Footwear

Secondary Diagnosis - I have further determined that the patient has one or more of the following conditions associated with Diabetes:

ICD-10 Description

___ **E11.40** Diabetes

___ G99.0 Peripheral neuropathy with callus formation

___ L84 History of Pre-ulcerative Callus

___ I 87.2 Poor Circulation

___ M21.969 Foot Deformity

___ Z89 .History of Partial or Complete Amputation:

☐.429 Other Toe; ☐.419 Great Toe; ☐.439 Foot

___ L97 .History of Ulceration:

☐ .409 Heel of Mid Foot; ☐ .509 Other Part of Foot

Prescription

	HCPCS CODE		# OF PAIRS
Diabetic Shoes	A5500	☐	1
Custom Inserts	A5513	☐	3
Ankle Gauntlet	L1902	☐	1
Toe Filler	L5000	☐	
Heat Moldable Inserts	A5512	☐	3

Notes____

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I certify that I am treating this patient under a comprehensive plan of care for his/her diabetes. I have evaluated this patient's medical condition and determined that the patient needs therapeutic depth shoes, molded inserts and/or ankle gauntlets. I certify that the information provided is true and correct.

Date of Service: _____/_____/______ NPI # ________________

Physician Name: ____

Address: ____ City: ______________________

State: _____ Zip: _________ Phone: ______________________ FAX: ______________________

Physician Signature: ______________________________________ Date: _____/_____/_____

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