

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY FOR
THERAPEUTIC DIABETIC SHOES AND INSERTS

Patient: _____

Provider Number: 1518932631

I certify that all of the following statements are true:

*Required: This patient has diabetes mellitus ICD-10-CM code: _____

(E10.10 - E13.9)

*(Circle all that apply)

- Foot ulcers
- Previous amputation of the contralateral foot, or part of either foot, due to a micro-vascular disease secondary to diabetes
- History of previous ulceration of either foot
- Peripheral neuropathy with evidence of callous formation of either foot
- Deformity of either foot, that is, rocker bottom foot or Charcot foot
- Documentation of compromised vascular disease in either foot
- Positive monofilament examination indicating diabetic neuropathy

*At least one of following are required for custom orthotics (HCPCS code A5513) and/or shoes (code A5501). Circle all that apply:

- Diabetes mellitus with neurological manifestations
- Diabetes mellitus with peripheral circulatory disorders
- Diabetes mellitus with other specified disorders (amputations, significant deformities and/or pre-ulcerations)

I am treating this patient under a comprehensive plan of care for his/her diabetes.

This patient needs special shoes (off-the-shelf or custom-molded) and/or inserts because of his/her diabetes.

Items prescribed: Extra Depth Diabetic Shoes & Diabetic Insoles

Physician name (printed): _____ MD/DO

Address: _____

Telephone Number: _____

Provider ID Number: _____

California Medical License Number: _____

Physician Signature (original): _____ MD/DO Date: _____



Orthotic & Prosthetic Centers - SFGH
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Patient Card/Sticker

Orthotics	
Spinal/Cranial	
<input type="checkbox"/>	HALO (L0859, L0810)
<input type="checkbox"/>	Cervical Collar (Miami-J) (L0174)
<input type="checkbox"/>	CTLSO (L0486, L0200)
<input type="checkbox"/>	LSO (Lumbo-Sacral Orthosis) (L0631)
<input type="checkbox"/>	Maternity Support (L0643)
<input type="checkbox"/>	Protective Helmet (A8001)
<input type="checkbox"/>	Soft Collar (L0120)
<input type="checkbox"/>	TLSO Clamshell (Fracture Control) (L0486)
<input type="checkbox"/>	TLSO Hyperextension (Jewett) (L0472)
<input type="checkbox"/>	Other:
Lower Extremity	
<input type="checkbox"/>	Achilles/Heel Wedge (L3300)
<input type="checkbox"/>	AFO Consult (Ankle Foot Orthosis)
<input type="checkbox"/>	OA/Ligamentous Knee Orthosis (K0902, L2610)
<input type="checkbox"/>	Figure 8 Ankle Stabilizer (L1906)
<input type="checkbox"/>	Custom Foot Orthotics (FFO's) (L3649)
<input type="checkbox"/>	Post Op ROM KO (L1833) *Please specify ROM
<input type="checkbox"/>	Hip Abduction Orthosis (L1686, L2624) *Please specify ROM
<input type="checkbox"/>	Multipodus AFO/ Plantar Fasciitis AFO (L4397)
<input type="checkbox"/>	PFS AFO (L4397)
<input type="checkbox"/>	Post-Op Shoe/ Pressure Relief (L3260)
<input type="checkbox"/>	Knee Immobilizer (L1830)
<input type="checkbox"/>	Neoprene Hinged Knee Orthosis (L1812)
<input type="checkbox"/>	Stirrup/Aircast (L4350)
<input type="checkbox"/>	Tibial Fracture Brace (Sarmiento) (L2116, L2180, L2840)
<input type="checkbox"/>	Walking Boot (CAM/Bledsoe Boot) (L4361)
<input type="checkbox"/>	Other:
Upper Extremity	
<input type="checkbox"/>	Shoulder Immobilizer (L3660)
<input type="checkbox"/>	Ultrasling (Arm Sling w/abd pillow) (L3675)
<input type="checkbox"/>	Wrist Splint (L3908)
<input type="checkbox"/>	Wrist Splint w/Thumb Immobilization (L3809)
<input type="checkbox"/>	Humerus Fracture Orthosis (Sarmiento) (L3980, L3995)
<input type="checkbox"/>	Cuff & Collar (L3670)
<input type="checkbox"/>	Post-Op ROM Elbow Orthosis (L3780)
<input type="checkbox"/>	Other:

Diabetic Orthotics	
<input type="checkbox"/>	Diabetic Extra Depth Therapeutic Shoes (A5500)
<input type="checkbox"/>	Diabetic Custom/OTS Orthotics (A5513, A5512)
<input type="checkbox"/>	Other:
Pediatric Orthotics	
<input type="checkbox"/>	Pavlik Harness (L1620)
<input type="checkbox"/>	Supra Malleolar Orthoses (SMO's) (L1907)
<input type="checkbox"/>	Ponsetti AFO's (L1971, L3380x2)
<input type="checkbox"/>	Dennis Brown Bar (L3150, L2768)
<input type="checkbox"/>	Straight Last Shoes (L3201)
<input type="checkbox"/>	FFOs / Gait Plates
<input type="checkbox"/>	Rhino Cruiser (L1660, L2830)
<input type="checkbox"/>	Neoprene Hinged Elbow Orthosis (L3760)
<input type="checkbox"/>	Other:
Prosthetics	
Amputation Level	
<input type="checkbox"/>	Trans-Tibial (Below-Knee)
<input type="checkbox"/>	Trans-Femoral (Above Knee)
<input type="checkbox"/>	Partial Foot
<input type="checkbox"/>	Upper Extremity
Side	
<input type="checkbox"/>	Right
<input type="checkbox"/>	Left
<input type="checkbox"/>	Bilateral
Service	
<input type="checkbox"/>	Pre-Operative Consult (Possible Amputation)
<input type="checkbox"/>	Post-Operative Consult (Rehab Orientation)
<input type="checkbox"/>	Residual Limb Shrinker (L8440, L8460)
<input type="checkbox"/>	Limb-Guard (L5460)
<input type="checkbox"/>	Existing Prosthesis Evaluation
<input type="checkbox"/>	TMA Shoe (L3260)
<input type="checkbox"/>	Other:

Dx: _____ ICD10: _____ Side: L R Bilateral

Reason for referral: _____

Date: _____ MD Name Printed: _____ NPI #: _____

Unit: _____ MD Signature: _____ License #: _____