BINSON'S
Medical Equipment & Supplies
Since 1953

Clear Form

ACHC ACCREDITED

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

(to be completed by an M.D. or D.O.)

Date: _____ HIC#: _____

Account Number: _____ Telephone #: _____

Patient's Name: _____ DOB: _____

Patient's Address: _____ Gender: _____

I certify the following statements are true and I AM ATTACHING CHART NOTES ***to support each diagnosis.***
Medical Necessity for item(s) listed:

_____

_____

1. **This patient has Diabetes Mellitus** ☐ Insulin Treated ☐ Non-Insulin Treated
   (Fill in required ICD10 Code)
2. **This patient has one or more of the following conditions (check all that apply):**

		ICD10
☐	A) History of partial or complete amputation of the foot	
☐	B) History of previous foot ulceration	
☐	C) Peripheral neuropathy with evidence of callus formation	
☐	D) History of pre-ulcerative callus	
☐	E) Foot deformity	
☐	F) Poor circulation	

3. ☐ Yes ☐ No **I am treating this patient under a comprehensive plan of care for his/her diabetes.**
4. ☐ Yes ☐ No **This patient requires diabetic shoes (extra depth or custom-molded) due to his/her diabetes.**

Rx

☐	Diabetic Shoes (off the shelf style)	Quantity = 2/each (1 Pair)	A5500
☐	Diabetic Shoes, Custom Fabricated	Quantity = 2/each (1 Pair)	A5501
☐	Diabetic insoles (off the shelf)	Quantity = 6/each (3 Pairs)	A5512
☐	Diabetic insoles, Custom Fabricated	Quantity = 6/each (3 Pairs)	A5513, A5514
☐	Toe Filler, Custom Fabricated	Quantity = 1/each	L5000

Other _____

LENGTH OF NEED = 12 months

NOTE: Prescribing physician (M.D., D.O.) may be different from certifying physician but must be knowledgeable in the fitting of diabetic shoes and inserts.

Physician's Printed Name: _____ NPI: _____

Address _____

Phone #: _____ Fax: _____

Physician's Signature: **X** _____ Date: **X** _____

Binson's Center Line Location (Main)
1-888-246-7667
FAX: 1-586-755-2322

WRITTEN ORDER FOR DIABETIC SHOES and DIABETIC INSOLES

Date: _____

Name: _____

Description of prescribed items: (check all that may apply)	**Quantity**
☐ Diabetic shoes (off the shelf style) A5500	1 pair
☐ Diabetic shoes (CUSTOM fabricated) A5501	1 pair
☐ Diabetic insoles (off the shelf style) A5512	3 pairs
☐ Diabetic insoles (CUSTOM fabricated) A5513, A5514	2 or 3 pairs
☐ Toe filler (CUSTOM fabricated – for partial foot amputees)	1 each

Length of need: 12 months

Physician's
Printed Name: _____

Physician's Signature: _____ Date: _____

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