Active Medical 120 Prosperous Place Suite 103 Lexington, KY 40509

Ph:859-421-1195 Fax:855-244-3350

Diabetic Verification Form MD or DO (NP or PA w/attestation)

Patient Name: _____ DOB: _____

I certify that all the following statements are true:

1) This patient has diabetes mellitus. ICD-10 Code: E10.4, E11.4, Z79.4, Z79.84

2) This patient has one of the following conditions:

(check all that may apply)

- ☐ History of partial or complete amputation of the foot
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ History of previous foot ulceration
- ☐ Foot deformity
- ☐ History of pre-ulcerative callus
- ☐ Poor circulation

3) Within the past 6 months, an exam has been performed and qualifying condition(s) have been documented.

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

5) This patient needs special shoes (depth or custom-molded) and/or inserts because of his/her diabetic condition.

Certifying Physician Information: (must be signed by a MD or DO)

Signature: _____ Date: _____

Name: _____

Address: _____

NPI #: _____

PLEASE FAX TO 855-244-3350 WITH OFFICE NOTES, INSURANCE AND DEMOGRAPHIC INFO.

Active Medical 120 Prosperous Place Suite 103 Lexington, KY 40509

Ph:859-421-1195 Fax:855-244-3350

Prescription for Therapeutic Footwear

Patient Name: _____ DOB: _____

Check all that apply:

- ☐ Diabetes Mellitus: ICD-10: E10.4, E11.4, Z79.4, Z79.84
- ☐ Edema (R60)
- ☐ Neuroma (D36.10)
- ☐ Corn(s) (L84)
- ☐ Ankle Instability (M25.373)
- ☐ Drop Foot (M21.379)
- ☐ Posterior Tib. Disorder (M76.829)
- ☐ Peripheral Vascular Disease (I70.2)
- ☐ Neuropathy (E11.41)
- ☐ Hammertoe(s) (M20.4)
- ☐ Bunion(s) (M20.1)
- ☐ Ulcer(s) (L97.521)
- ☐ Callus(es) (L84)
- ☐ Amputation(s) (Z89.4)
- ☐ Charcot Deformity (M14.67)
- ☐ Other: _____

The patient requires:

- ☐ Diabetic Footwear, non-custom (A5500) – 1 pair
  With Custom molded inserts (A5514) – 3 pairs ***

Lesions requiring offloading: L 1 2 3 4 5 R 1 2 3 4 5

- ☐ Non custom, heat moldable inserts (A5512) – 3 pairs
- ☐ Toe Filler (L5000)

Clinician Name: _____NPI#_____

Signature: _____ Date: _____