Hale Center Clinical Pharmacy LLC	Phone 806-839-2466 Fax 806-839-3170 601 Ave G Hale Center, TX 79041	**DIABETIC SHOE ORDER**

DATE OF ORDER:_____ START DATE OF THE ORDER (if different):_____

Patient's Name:_____ HIC #:_____

Patient's Address:_____

Items ordered: [ ] 1 pair Diabetic Shoes Extra Depth (A5500)

[ ] 3 pair Inserts Heat Moldable (A5512) OR [ ] 3 pair Inserts Custom Molded (A5513)

ICD-10 DIAGNOSIS_____

I certify that all of the following statements are true:

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions below is present. If requested by the supplier, you must provide copies of those records.

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1. **This patient has diabetes mellitus.**
2. **This patient has one or more of the following conditions:**
   (circle all that apply)
   a) **History of partial or complete amputation of the foot.**
   b) **History of previous foot ulceration.**
   c) **History of pre-ulcerative callus.**
   d) **Peripheral neuropathy with evidence of callus formation.**
   e) **Foot deformity.**
   f) **Poor Circulation.**
3. **I am treating this patient under a comprehensive plan of care for his/her diabetes and the date of their last office visit during which we addressed their diabetes management was:_____**

Physician's Signature:_____ Date:_____

Physician's Name	NPI #	Phone #
Address		Fax #

Provider, please fax this form along with relevant documentation of the foot exam from the patient's medical records to 806-839-3170.