Brownfield's
prosthetic & orthotic technologies
since 1949
122 N. 5th Street Boise, ID * Phone 342-4659 * 342-8211

Rx

One pair of extra – depth shoes with three (3) pairs of diabetic inserts.

_____
_____
_____
_____

_____
Physician's Signature

_____
NPI# **DATE**

PLEASE BE SURE TO FILL OUT BOTH THE LEFT & RIGHT SIDE OF THIS FORM

****

Statement of Certifying Physician

Patient's Name _____
Address_____
City _____State_____Zip_____
Phone _____ SS# _____
DOB _____ □ Male □ Female

Physician's Information: (must be filled out by the Physician treating patient for Diabetes)
I certify that the following statements are true:
**** The patient has diabetes mellitus** (patient must have DM to be covered by Medicare) □ **YES** □ **NO**
**** DIAGNOSIS CODE: (circle one) 250.00, 250.02, 250.01, 250.03 Other:**_____

The patient has one or more of the following conditions:
(check all that apply)

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

The patient is being treated under a comprehensive plan of care for Diabetes. This patient needs depth inlay, extra depth shoes with multiple density inserts because of his or her Diabetes. □ **YES** □ **NO**

_____
Physician's Name (Please Print First, Last) **NPI #** **DATE**

_____
Physician's Signature **Address & Phone Number** **DATE**