



Orthopedic & Sports Medicine Clinic

4411 Alby Street, Alton, IL 62002

(618) 474-8052 • Fax (844) 814-7597

Prescription for Diabetic Shoes and Orthotic Inserts

Patient Name: _____ DOB: _____

Patient Phone: _____ Address: _____

ICD-10 Diagnosis Code(s): _____

- Patient has diabetes mellitus
- Patient has one or more of the following:
- | | |
|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Neuropathy with callus | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Foot deformity | <input type="checkbox"/> Plantar fasciitis |
| <input type="checkbox"/> Previous ulcer | <input type="checkbox"/> Bunion |
| <input type="checkbox"/> Previous amputation | <input type="checkbox"/> Hammer toe |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Flat feet |
| | <input type="checkbox"/> Chronic foot pain |

Rx Diabetic Shoes, 1 Pair

Custom Inserts (up to 3 pairs – Medicare allowance)

Provider Certification:

I certify this patient has diabetes and meets criteria for therapeutic shoes and/or inserts.

Provider Signature: _____ Date: _____

Provider Name: _____ Provider NPI: _____

Phone: _____ Address: _____

Primary Insurance: _____

HOW TO SEND PRESCRIPTIONS

Completed prescriptions can be sent to our office by
FAX, EMAIL, or through our WEBSITE:

FAX: (844) 814-7597

EMAIL: info@brucevestmd.com

VISIT: www.myfeetnow.com



Please include recent chart notes supporting diagnosis and qualifying conditions.