PROSTHETICARE

Diabetic Verification phone# 817-336-8293 fax# 817-336-9017

PATIENT INFORMATION

Patient Name (Last, First, MI)	Patient DOB	Device Type
		A5500/A5513

Street Address	City, State, Zip Code

The physician listed below certifies that all of the following statements are true: *(please fill in all *)*

1. This patient has diabetes mellitus. *** ICD 10** _____
2. This patient had the following conditions.

***PLEASE CHECK ALL THAT APPLY (must check at least one)**

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

3. I am treating this patient under comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician Name	Physician Address

Physician Office Phone	Physician Fax	Physician NPI

The above procedures are appropriate for this patient and are deemed medically necessary.

_____

Physician Signature **Date**