Fax to 270-747-8779

Prescription

THERAPEUTIC FOOTWEAR
FOR PERSONS WITH DIABETES & COMPLICATIONS

Patient Name _____ **DOB** _____

Patient Telephone_____ **Date of Last Visit**[1]_____

Diagnosis (ICD-10)_____

℞ **Prescription** (choose one shoe choice and one orthotic choice)

	Shoes		Accommodative Orthotics[2]	
	☐ Depth Shoes, off the shelf (A5500)	1 pair	☐ Non-custom, heat moldable orthotics (A5512)	3 pairs[3]
	☐ Custom Molded Shoes (A5501)[4]	1 pair	☐ Custom molded orthotics (A5513) Reason required: _____	3 pairs

☐ Orthopedic Shoe modifications, or any other instructions: _____

_____

Prescriber Signature _____ Date _____

Prescriber Name (Printed) _____NPI _____

Prescriber Telephone _____Fax _____ Rev 08/10/2018

Prescriber must be Pecos Enrolled (MD, DO, DPM, PA, Licensed Nurse Practitioner or Clinical Nurse Specialist)

MEDICARE RULES

[1] Footwear must be dispensed prior to six months from the date of the last visit with the referring doctor.

[2] Orthotics prescribed for use in patient's own shoes are provided if shoes meet Medicare criteria for safety.

[3] 3 pairs orthotics * 4 months duration = 12 months of use.

[4] A custom molded shoe (A5501) is covered when the beneficiary has a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be documented.

Boston Pedorthic

By Appointment
1929 Commonwealth Ave, Brighton 02135 ◆ MBTA B Line to Chestnut Hill Avenue ◆ Free Parking
eFax: (270) 747-8779 ◆ Tel: (617) 787-8779 ◆ Tax ID 59-3769572 ◆ NPI 1275504102
www.bostonpedorthic.com/diabetes