comfort footwear etc
west hartford

SHOES & ORTHOTICS
208 Park Road, West Hartford, CT, 06119
Phone: 860.232.1868 | Fax: 860.761.2658
info@comfortfootwearetc.com

Date____/_____/_____ D.O.B.____/____/______ Patient Name______________________________

Address ____

FOOTWEAR PRESCRIPTION

DIAGNOSIS

	Rt	Lt		Rt	Lt		Rt	Lt
Diabetes E11. _____			Charcot	☐M14.671	☐M14.672	Neuroma	☐G57.61	☐G57.62
Achilles Contracture	☐M67.01	☐M67.02	Equinus Foot Aquired	☐M21.6X1	☐M21.6X2	Plantar Fasciitis	☐M72.2	
Achilles Tendinitis	☐M76.61	☐M76.62	Hallux Rigidus	☐M20.21	☐M20.22	Pes Planus (acq)	☐M21.41	☐M21.42
Arthritis (Osteo)	☐ M19.071	☐M19.072	Hammer Toes	☐M20.41	☐M20.42	Pes Planus (cong)	☐Q66.51	☐Q66.52
Apophysitis	☐M92.71	☐M91.72	Heel Spur	☐M77.31	☐M77.32	Pes Cavus	☐Q66.7	
Bunion	☐M20.11	☐M20.12	Leg Length Discr	☐M21.763	☐M21.764	Sesmoiditis	☐M89.8X9 Bone	
Corns & Calluses	☐L84		Metatarsalgia	☐M77.41	☐M77.42	Other______	☐M94.8X9 Cartilague	

FOOTWEAR

- ☐Diabetic (Medicare patients please have primary physician provide certifying statement below)
- ☐Extra Depth
- ☐Custom Molded
- ☐High Toe Box
- ☐Chukka
- ☐Rocker Bottom
- ☐Shoe Lift ☐1/2 ☐3/4 ☐1" ☐Other____

☐ **Arizona Type AFO**
☐ **Richie Type AFO**

ORTHOTICS

- ☐Prefab Plastazote Insert, Heat Molded (A5512) (L3030)
- ☐Plastazote Insert Custom Molded To The Model (A5513) (L3002)
- ☐Premolded Orthotics (L3040)
- ☐Toe Filler (L5000)
- ☐Functional Orthotics (L3020)
- ☐Sport Orthotics Semi-Rigid (L3010)
- ☐Casual Orthotics Semi Rigid Everyday (L3020)
- ☐Berkley Shell, UCB Type (L3000)

Met Pads ______ Heel Spur Pad _____ Lift 1/4 ____ 3/8_____
Orthotic Quantity (pairs) 1☐ 2☐ 3☐

Length of need for items prescribed: ☐6 MONTH ☐99 Year ☐Other ___________

Physician Signature: ________________________ Physician Name: ________________________

Address: ____ NPI: ____________________ Phone: ________________

NOTE: For coverage by Medicare under the therapeutic shoes for diabetes program. **This document must be signed by the M.D. or D.O. managing the patient's systematic diabetic condition and the statements documented below must be documented in the patient's medical record.** This SCP must be accompanied by a signed diabetic footwear prescription form.

I CERTIFY THAT ALL OF THE FOLLOWING STATEMENTS ARE TRUE:

1. **This patient has diabetes melitus - ICD-10 Code: E11.__________**
   (ICD-10 Diagnosis Code Required)
2. **This 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
   ____Peripherial neuropathy with evidence of callus formation
   ____Foot deformity
   ____Poor circulation
3. **I am treating this patient under a comprehensive plan of care for his/her diabetes.**
4. **This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.**
5. **This patient was seen in a face to face visit by me on DATE:________________**
6. **A copy of the Patient's clinical documentation including a detailed description of the qualifying foot condition(s) listed above is enclosed.**
7. **The above information is documented in the Patient's medical record.**

DELIVERY OF SHOES MUST BE WITHIN 3 MONTHS OF THE DATE SIGNED

____
Physician Name (printed)

____
Physician Signature

____
Physician Address

____
Physician **NPI# (THIS IS IMPORTANT)**
☐M.D. ☐D.O. (PLEASE CHECK ONE)

____
Physician Phone #