Prescription & Letter of Medical Necessity for Orthopedic Shoes

Patient Name: _____
Last First Middle

Address: _____
City State Zip Code

Medicare ID# _____

Date of Birth: _____ Gender: ____ Male ____ Female

Physicians RX

I certify that the following statement is true:

The diagnosis indicated Patient has following foot condition:
(check Dx that applies)
DX

_____ M20.40 - Hammer Toe
_____ M20.10- Hallux Vaigas
_____M77.30 - Calcaneal Spur
_____M20.10 - Bunion
_____M72.2 - Plantar Fasciatis
_____M77.40 - Metatarsalgia
_____ M19.079 - OA
_____ Q66.7 - Cavus Foot
_____ M21.969 - Foot Deformity
_____ M21.759 - Unequal Leg Length

_____ M20.5X9 Claw Toe
_____ M12.9- Arthropathy
_____ M06.9 - RA
_____ M25.9- Disorder of Ankle & Foot
_____ M25.673/M25.676 - Joint Stiffness
_____ G90.09 - Neuropathy
_____ M21.40 - Pes Planus
_____ I87.9/I99.9 - Poor Circulation
_____E11.9 Type 2 Diabetes Mellitus

I am treating this patient under a comprehensive plan of care.
This patient needs extra depth shoes with multiple density inserts because of foot condition checked above.
I certify that all of the conditions checked above are in my doctor's notes

_____ _____
Physician Signature M.D or D.O or D.P.M Date

Physicians Information:

_____ _____
Doctor's Name NPI #

Address: _____
City State Zip Code

Office Phone: _____