

Office Use Only



Shoe Choice Size: \_\_\_\_\_

1<sup>st</sup> Choice: \_\_\_\_\_

2<sup>nd</sup> Choice: \_\_\_\_\_

Phone: 770-935-6043

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Duluth, GA 30096  
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Fax: 678-264-2121

**Prescription & Letter of Medical Necessity for Therapeutic Shoes and/or Custom Inserts**

**FILL FIRST BOX OR ATTACH PT DEMOGRAPHIC SHEET**

First Name:		Last Name:		DOB:	
Email:		Address:			
Phone:		City:		State:	Zip Code:
Insurance Name:				Insurance ID:	

**ICD-10 Diagnosis Code:**

- |  |   |
|--|---|
| <input type="checkbox"/> <b>E10.9</b> – Type I Diabetes without complications  | <input type="checkbox"/> <b>M21.40 / M21.41</b> Fallen Arch/Pes Planus  |
| <input type="checkbox"/> <b>E10.8</b> – Type I Diabetes with complications     | <input type="checkbox"/> <b>Z89.4</b> – Absence Toe   |
| <input type="checkbox"/> <b>E11.9</b> – Type II Diabetes without complications | <input type="checkbox"/> <b>M20.4</b> – Arthropathies <input type="checkbox"/> <b>Other</b> _____               |
| <input type="checkbox"/> <b>E11.8</b> – Type II Diabetes with complications    | <input type="checkbox"/> <b>M77.4</b> – Metatarsalgia <input type="checkbox"/> <b>M72.2</b> – Plantar Fasciitis |

The Patient must have a **Documented Hx** of one or more of the following to meet Medical Necessity

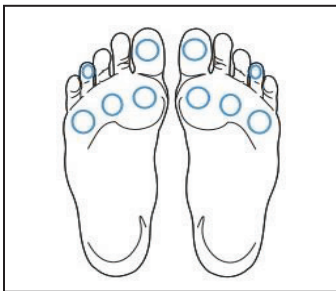
History of previous foot ulceration

- |  |   |
|--|---|
| <input type="checkbox"/> History of pre-ulcerative callus                        | <input type="checkbox"/> Foot Deformity   |
| <input type="checkbox"/> Peripheral neuropathy with evidence of callus formation | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> History of partial or complete amputation of the foot   |   |

**Physician's Order:**

- ☐ **A5500** – For diabetics only. Fitting (including follow-up) custom preparation and supply of off-the shelf depth inlay shoes manufactured to accommodate multi-density inserts.
- ☐ **A5512** – For diabetics only, multi-density Pre-fabricated inserts available ONLY in whole size, medium width inserts.
- ☐ **A5514** – For diabetics only, multi-density inserts, custom molded from model of patient's foot Total contact with patient's foot.
- ☐ **L3050** – Custom Arch orthotics for both Left and Right Foot
- ☐ **L3060** – Custom Arch orthotics Longitudinal for both Left and Right Foot

**Clinical Evaluation:**



	LT	RT		RT	LT
Callus	<input type="checkbox"/>	<input type="checkbox"/>	Hammer toes	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Overlapped toes	<input type="checkbox"/>	<input type="checkbox"/>
Heelspur	<input type="checkbox"/>	<input type="checkbox"/>	Amputated toes	<input type="checkbox"/>	<input type="checkbox"/>
Bunion	<input type="checkbox"/>	<input type="checkbox"/>	Metatarsalgia	<input type="checkbox"/>	<input type="checkbox"/>
Bunionette	<input type="checkbox"/>	<input type="checkbox"/>	Plantar fasciitis	<input type="checkbox"/>	<input type="checkbox"/>
Charcot	<input type="checkbox"/>	<input type="checkbox"/>	Toe pain	<input type="checkbox"/>	<input type="checkbox"/>

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



(Physician Signature M.D. or D.O.)

Date

Physician Information: Dr. Name \_\_\_\_\_ UPIN # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

## MEN'S SPORT

Running/Training, Recreational Walking,  
Active Lifestyle



## MEN'S CASUAL

Casual Comfort, Working/Walking,  
Active Lifestyle



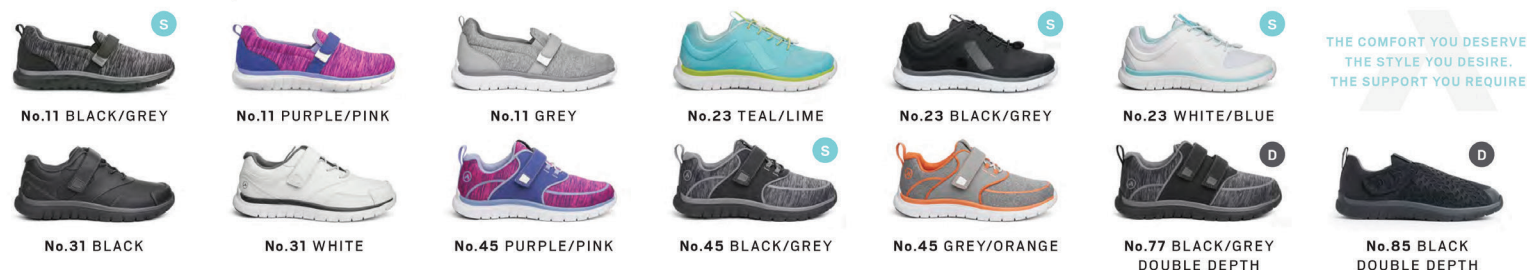
## MEN'S TRAIL

Hiking/Trail, Recreational Walking,  
Active Lifestyle



## WOMEN'S SPORT

Running/Training, Recreational Walking,  
Active Lifestyle



## WOMEN'S CASUAL

Casual Comfort, Working/Walking,  
Active Lifestyle



## WOMEN'S TRAIL

Hiking/Trail, Recreational Walking,  
Active Lifestyle



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