

Part A

PLEASE TAKE THIS TO YOUR FAMILY PHYSICIAN OR THE PHYSICIAN YOU ARE SEEING FOR YOUR DIABETES.

## STATEMENT OF CERTIFYING PHYSICIAN; DIABETIC THERAPEUTIC FOOTWEAR

PATIENT: \_\_\_\_\_

PHONE #: (\_\_\_\_) \_\_\_\_ / \_\_\_\_ BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

MEDICARE #: \_\_\_\_\_

SUPPLEMENT #: \_\_\_\_\_

ICD-9 CODE(S): \_\_\_\_\_ (ICD-9 DIAGNOSIS CODES 250.00-250.91)

I CERTIFY THAT ALL OF THE FOLLOWING INDICATED STATEMENTS ARE TRUE:

(PLEASE PLACE A CHECKMARK BY ALL APPROPRIATE STATEMENTS)

- \_\_\_\_\_ 1. THIS PATIENT HAS ONE OR MORE OF THE FOLLOWING CONDITIONS:  
(CHECK ALL THAT APPLY)
- \_\_\_\_\_ A. HISTORY OF PARTIAL OR COMPLETE AMPUTATION OF FOOT.
  - \_\_\_\_\_ B. HISTORY OF PREVIOUS FOOT ULCERATION.
  - \_\_\_\_\_ C. HISTORY OF PRE-ULCERATIVE CALLUS.
  - \_\_\_\_\_ D. PERIPHERAL NEUROPATHY WITH EVIDENCE OF CALLUS FORMATION.
  - \_\_\_\_\_ E. FOOT DEFORMITY.
  - \_\_\_\_\_ F. POOR CIRCULATION.
- \_\_\_\_\_ 2. I AM TREATING THIS PATIENT UNDER A COMPREHENSIVE PLAN OF CARE FOR DIABETES.
- \_\_\_\_\_ 3. THIS PATIENT NEEDS SPECIAL FOOTWEAR (DEPTH OR CUSTOM MOULDED FOOTWEAR) AND/OR INSERTS BECAUSE OF THEIR DIABETIC CONDITION.
- \_\_\_\_\_ 4. THIS PATIENT IS \_\_\_\_\_ INSULIN DEPENDENT/\_\_\_\_\_ NON-INSULIN DEPENDENT.

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN'S PHONE: (\_\_\_\_) \_\_\_\_ / \_\_\_\_ NPI: \_\_\_\_\_

Return to:

**John Allen Shoes**  
214 Owen Drive  
Post Office Box 53237  
Fayetteville, North Carolina 28305  
(910) 484-3161 Phone

***This form should be accompanied by a prescription from your physician.***

**PLEASE CALL FOR APPOINTMENT**

**JOHN ALLEN SHOES**

PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code)

PATIENT PHONE: ( ) \_\_\_\_\_ BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEX: M F

PRIMARY INSURANCE (Name/Address) \_\_\_\_\_

PRIMARY POLICY NUMBER: \_\_\_\_\_

SUPPLEMENTAL INSURANCE (Name/Address) \_\_\_\_\_

SUPPLEMENTAL POLICY NUMBER: \_\_\_\_\_ SUPPLEMENTAL POLICY PHONE NUMBER: ( ) \_\_\_\_\_ / \_\_\_\_\_

ARE YOU PRESENTLY PRESIDING AT HOME? Y N NURSING HOME? Y N

I authorize the release of any information necessary to process this claim and request that payment of all government or private benefits be made to myself or to the party who accepts assignment for the services listed below. In addition, my signature indicates that I received all services as prescribed by my physician. I understand should my insurance not make appropriate payment nor cover items dispersed, I will be personally responsible for payment.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**ARE YOU  
DIABETIC?  
ARE YOU  
MEDICARE  
AGED?**



If your answer is "yes" to both these questions, then please be aware you may be eligible for the following preventative Medicare services...

Thanks to the U.S. Congressional Diabetic Therapeutic Shoe Bill, eligible Medicare patients receive one pair of special footwear and with appropriate inserts each calendar year.

John Allen Shoes can provide these services for you.

Should you have any questions or need further information regarding the Medicare Diabetic Therapeutic Shoe Bill, please contact us at 910-484-3161.

**JOHN  
ALLEN  
SHOES®**

214 Owen Drive  
Fayetteville, NC 28304

PLEASE FILL OUT PART A AND PART B  
AND RETURN TO THE STORE

## Instructions for Diabetic Form

- 1) Take form to your family or primary care doctor to fill out.
- 2) Make sure that under heading #1, at least one of the letters A-F, has been checked.
- 3) Be sure the doctor writes you a prescription for “Diabetic Shoes & Insole” to go along with this form.
- 4) Once you have both of these documents, please call us at 910-484-3161, to make an appointment. Diabetic fittings are by appointment only!
- 5) When you come for your appointment make sure you have the following:
  - a. Diabetic Form
  - b. Prescription
  - c. Medicare Card & Secondary Insurance Card (only needed if this is your first time or if any of your information has changed since your last fitting with us).
  - d. Picture ID (if we do not already have on file)
- 6) Medicare MUST be primary (No HMOs)
- 7) If for any reason you are unable to keep your appointment, please let us know.
- 8) If you are a physician, please remember that we need the original copy mailed to us. We cannot use a faxed or emailed copy.

