



Prosthetics and Orthotics Provider Order Form Plus

Diabetic Attestation

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Imprint or MR# & DOB

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a) (1) of the Medicare Law. When ordering items for which Medicare reimbursement will be sought, physicians should order only those items that are necessary for the diagnosis and treatment of a patient.

PATIENTS NAME:

PRESCRIPTION:

DIAGNOSIS:

I certify that all items ordered are medically necessary

Date: _____ Time: _____ Ordering Provider: _____ UPIN# _____

Chart Location: Provider Orders

This form MUST be completed by the attending physician before we can evaluate a diabetic patient receiving Medicare/Medicaid for services to be covered. Do not use this form if the patient is NOT diabetic.

Statement of Certifying Physician for Therapeutic Shoes

I certify that all of the following statements are true

1. This patient has diabetes mellitus (circle one) YES NO
2. This patient has one or more of the following conditions (circle all that apply)
 - i) History of partial or complete amputation of the foot
 - ii) History of previous foot ulceration
 - iii) History of pre-ulcerative callus
 - iv) Peripheral neuropathy with evidence of callus formation
 - v) Foot deformity
 - vi) Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes
YES NO
4. This patient needs special shoes (depth of custom-molded shoes) because of his/her diabetes.
YES NO

Physician Signature: _____ Date: _____ Time: _____

Physician Name

Printed: _____ Physician

UPIN: _____ Physician NPI: _____