TRUARCH FOOT AND BRACE
2307 S. 3RD STREET
TERRE HAUTE, IN 47802-3048
P 812-232-0910
F 812-232-0936

TRUARCH FOOT AND BRACE
3101 N GREEN RIVER RD STE 730
EVANSVILLE, IN 47715
P 812-402-9511
F 812-4020-0911

DIABETIC SHOES/INSERTS—CMN—PRESCRIPTION

Patient Name: _____ **DOB**: _____ **Phone #**:_____

1. This patient has Diabetes Mellitus. **Please check below which type of DM you are treating your patient for and applicable ICD-10 Dx Code**

DM without mention of Manifestation	☐ Dx Code: _____	**DM with Opthalmic Manifestations**	☐ Dx Code: _____
DM with Renal Manifestations	☐ Dx Code: _____	**DM with Neurological Manifestations**	☐ Dx Code: _____
DM with Peripheral Circulatory Disorders	☐ Dx Code: _____	**DM with Other specified Manifestations**	☐ Dx Code: _____
DM with Unspecified Complications	☐ Dx Code: _____	**OTHER Diabetes Mellitus**	☐ Dx Code: _____

2. This patient has the following co-existing conditions: **CHECK ALL THAT APPLY**
(If Checking "Other" Please provide Description & Dx Code

History of partial or complete amputation of the foot	☐ Amput great toe (Z89.411 RT) (Z89.412 LT) ☐ Amput other toe (Z89.421 RT) (Z89.422 LT) ☐ Amput foot (Z89.431 RT) (Z89.432 LT) ☐ Amput BK (Z89.511 RT) (Z89.512 LT) ☐ Amput AK (Z89.611 RT) (Z89.612 LT)	**Foot deformity**	☐ Charcot Foot *(M14.671 RT) (M14.672 LT)* ☐ Hallux Valgus *(M20.11 RT) (M20.12 LT)* ☐ Hammer Toe *(M20.41 RT) (M20.42 LT)* ☐ Foot Deformity *(M21.961 RT) (M21.962 LT)* ☐ Pronation of foot/ankle *(M21.071 RT) (M21.072 LT)* ☐ Other _____
History of previous foot ulceration	☐ Ulcer of heel & midfoot (L97.409) ☐ Ulcer other part of foot (L97.509) ☐ Other _____	**Poor Circulation**	☐ Peripheral Vascular Disease *(I73.9)* ☐ Poor Circulation *(I87.2)* ☐ Other _____
History of pre-ulcerative foot callus	☐ History of pre-ulcerative callus (L98.499)	**Peripheral neuropathy and evidence of callus formation**	☐ Polyneuropathy in diabetes (E08.42) **And** ☐ History of Callus (L84)
Other DX	☐ _____	**Other DX**	☐ _____

By signing below, I state that the patient named above has diabetes and is being treated by me under a comprehensive plan of care. All of the information contained in this statement is true and correct to the best of my knowledge and filed in the patient's permanent medical record. I authorize the use of this document by TruArch Foot & Brace as a dispensing authorization.

PRINT PHYSICAN NAME: _____

PHYSICIAN SIGNATURE: **X** _____ **Date**: _____ **NPI**:_____

***MEDICARE REQUIRES M.D. OR D.O. SIGNATURE**