**Prescription for Therapeutic Footwear and Inserts**

Patient Name: Date of Birth:

Dispense (**check one**)

\_\_\_\_ 1 pair of extra-depth **shoes** and 3 pair of heat molded multi-density **inserts**

\_\_\_\_ 1 pair of extra-depth **shoes** and 3 pair of custom molded multi-density **inserts**

\_\_\_\_ 1 pair of custom molded **shoes** and 3 pair of custom molded multi-density **inserts**

Medicare recommends patients with diabetes receive 3 pair of inserts to be rotated every 4 months

Additional modifications requested:

\_\_\_\_ Custom Toe Filler **Circle one**: Left Right B/L

\_\_\_\_ Elevation

\_\_\_\_ Other

Diagnosis:

Physician Signature: Date:

Physician Name: NPI#:

Address: