48531 Warm Springs Blvd. Fremont CA. 94539
Phone: 866.203.9810
Send Completed Form To:
Email: info@synergypo.com
Fax: 855.230.1468

Statement of Certifying Physician Order Form

PATIENT INFORMATION

Patient First Name	MI	Last Name	
Date of Birth	Gender ☐ Male ☐ Female	Social Security #	
Address	City	State	ZIP
Phone Number	Alternate Number	Email Address	

PATIENT INSURANCE INFORMATION

Primary Insurance ☐ Medicare ☐ Other		Secondary Insurance: (if applicable)	
Payer		Payer	
ID#	Group#	ID#	Group#
Phone		Phone	
Policy Holder Name		Policy Holder Name	

Supplies Needed

☐ Extra Depth Therapeutic Shoes (A5500)	Quantity -2 (1 Pair)
☐ Custom Inserts (A5514)	Quantity -6 (3 Pairs)
☐ Toe Filler for partial foot amputees (L5000)	Quantity -2
☐ Heat Molded Inserts (A5512)	Quantity -6 (3 Pairs)

Length of Need

Length of need in months: 1 pair per year

The Patient listed above has diabetes Mellitus with the following ICD-10 Diagnosis Code:

☐ E119 ☐ E109
☐ E1165 ☐ E1065 Other:

PHYSICIAN INFORMATION

I certify that the following statements are true:

2.) This Patient Has Diabetes Mellitus;

1.) This Patient Has one or more of the following conditions:

☐ Poor Circulation ☐ Other: _____
☐ History of pre-ulcerative callus: L84 ☐ Other: _____
☐ History of foot ulceration: Z86:31 ☐ Other: _____
☐ Foot Deformity

Hammertoes	☐ (RT) M20.41	☐ (LT) M20.42
Heel Spurs	☐ (RT) M77.31	☐ (LT) M77.32
Bunions	☐ (RT) M20.11	☐ (LT) M20.12

Other: _____

☐ History of partial or complete amputation of foot:

Foot	☐ (RT Foot) Z89.431	☐ (LT Foot) Z89.432
Great Toe	☐ (RT Foot) Z89.411	☐ (LT Foot) Z89.412
Ankle	☐ (RT Foot) Z89.441	☐ (LT Foot) Z89.442
Other Toe (S)	☐ (RT Foot) Z89.421	☐ (LT Foot) Z89.422

3.) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4.) This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Certifying Physician (Must be MD or DO, PECOS Enrolled)

I certify that I am treating this patient under a comprehensive plan of care for his/her diabetes. I am in agreement with the medical records prescribing physician for coverage criteria, and I have obtained, signed and dated the foot examination completed by the prescribing physicians. I **certify that I have thoroughly documented the patient's medical necessity for product (s) ordered and will provide the supplying required supporting documentation.**

Effective Date	Physicians Name	NPI	Phone	Fax
Physician Address	City	State	Zip	

Physician Signature (Must Be an M.D. or D.O)

Date

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