

1255 Vinus Street
Gilbert, WV 25621



Phone: (304)664.8883
Fax: (304) 664.9236

Thank you for choosing us as your location for diabetic shoes. We take pride in helping you select the best shoes possible to prevent complications that are common in diabetic patients.

Diabetic shoes are covered by most insurances annually if you meet one of the required qualifying conditions. Take the following paperwork to your physician to see if you qualify.

Once we receive the paperwork, we will call you and set up your initial appointment.

Thank you for choosing Carewell and feel free to call with any questions you may have.

Statement of Certifying Physician

Patient: _____

Patient Date of Birth: _____ Patient Phone: _____

1) This patient has diabetes mellitus:

- Type II
- Type I

2) QUALIFYING CONDITIONS: I have diagnosed and am including my notes showing that this patient has one of more of the following:

- Poor circulation
- Foot deformity
- Peripheral neuropathy with evidence of callus formation
- History of pre-ulcerative callus
- History or previous foot ulceration
- History of partial or complete amputation of the foot.

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

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

Physician Signature: _____

Physician Name: _____

NPI # _____ Date: _____

Physician Phone: _____

Physician Address: _____

Send these forms with most recent clinical notes to:

(Form 1 of 2)



Carewell Pharmacy
PO Box 280
Gilbert, WV 25621
Phone: 304.664.8883
Fax: 304.664.9236
E-mail: carewellpharmacywv@gmail.com

Prescription for Diabetic Shoes and Inserts

Patient: _____

Patient Date of Birth: _____ Patient Phone: _____

1) Type of shoes prescribed (check):

- Extra depth (A5500)- 1 pair, unless otherwise noted.

2) Type of inserts prescribed (check one):

- Heat Moldable (A5512)- 3 pairs, unless otherwise noted.

3) ICD-10 Code: _____

4) Any special instructions:

5) Check all that apply:

- Hammertoe(s)
- Edema
- Bunions
- Ulcer(s)
- Callus(es)
- Amputation(s)
- Charcot Deformity
- Fasciitis
- Neuroma
- Corn(s)
- Drop Foot
- Neuropathy
- Ankle Instability
- Other: _____

Physician Signature: _____

Physician Name: _____

NPI # _____ Date: _____

Physician Phone: _____

Physician Address: _____

Clinical Notes

Name of Physician or Organization: _____

Address of Physician or Organization: _____

Patient Name: _____

Patient Date of Birth: _____

Date of Exam: _____

Results of Foot Exam:

Reason for needing diabetic footwear:

List of medications that the patient currently takes to help treat diabetes:

Date written: _____

Provider's Signature: _____

(Paperwork must be signed by MD or DO)

**Send these forms with most recent clinical notes to:
(Form 2 of 2)**



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