

Specially designed to fit the diabetic foot and reduce diabetes foot pain and problems.

- Extra width and depth in the toe box and forefoot area helps prevent pressure on swollen feet, bunions, hammertoes and other problem areas.
- Padded heel counter prevents irritation
- Leather lining keeps feet cool and dry
- Padded tongue reduces friction and improves fit
- Finest quality top grain leather shapes to the feet for improved comfort
- Non-skid, long-wearing, light-weight outsole for better traction

One in four Americans with diabetes will develop potentially serious foot problems related to the disease. However, proper footwear can help diabetic patients avoid unnecessary complications.

Improve your comfort and protect your health with "Medicare-covered" Dr. Comfort Shoes from Bender's Prescription Shop!



The Finest Quality Diabetic Footwear Period!



3829 Frederick Blvd., St. Joseph 816-279-1668

OUTSIDE ST. JOSEPH, CALL BENDER'S TOLL FREE 1-800-633-9781

Take this brochure to your doctor to see if you qualify for assistance.

STATEMENT OF MEDICAL NECESSITY

STATEMENT TO CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Name: _____

Date of Birth: _____

I certify that all of the following statements are true:

- The patient has diabetes mellitus, ICD code:
 - 250.00 250.01 250.02
 - 250.03 Other
- The patient has one or more of the following conditions:
 - Previous amputation of the foot or part of the foot
 - History of previous foot ulceration
 - Pre-ulcerative callus formation with a history of callus formation
 - Foot deformity Poor circulation
- I am treating this patient under a comprehensive plan of care for his/her diabetes.
- This patient needs extra depth shoes with inserts because of his/her diabetes.

# UNITS	HCPCS CODE	PRESCRIPTION
1 pair	A5500	Extra-depth shoes
3 pair	A5512	Heat Moldable insert
3 pair	A5513	Custom Insert

Physician Signature: _____ Date: _____

Physician Name (Print) _____ NPI #: _____

Primary Care Office Address: _____

PRESCRIPTION FOR THERAPEUTIC SHOES

Patient Name: _____

HIC #: _____ Date: _____

Age: _____ Phone: _____

Address: _____

Per Statement of the Certifying Physician, the patient has one or more of the following foot conditions:

- Previous amputation Peripheral Neuropathy
- Foot Deformity Previous Ulceration
- Poor Circulation Pre Ulcerative Callus

Shoe Prescribed:

- Extra Depth
- Insert Prescribed: Heat Molded Custom Fabricated

Instructions: _____

NPI #: _____

Physician Name (Print) _____

Physician Signature: _____