

Receipt of Diabetic Shoes and Inserts

Delivery Address: _____

Ordering Provider: _____

Patient Name: _____ DOB: _____

Diagnosis Code(s): _____

Quantity	Prescribed Item and Description	HCPCS / OTC Code
	DIABETIC SHOES (Diabetic Shoe for density insert)	A5500 KX
	HEAT MOLDABLE ORTHOTICS (Mult dens insert direct form)	A5512 KX
	DIABETIC CUSTOM ORTHOTICS (Mult dens insert custom mold)	A5514 KX
	AMPUTATION FILLER (Partial foot, shoe insert w/ longitudinal arch, toe filler)	L5000 L R

Shoes (Indicate Model #/Style/Color/Size):

Given to patient:

(MA's initials)

_____ Copy of Delivery Documentation form

_____ Medicare DMEPOS Supplier Standards

_____ **SELF PAY**

_____ **ABN Signed**

_____ **Dm Shoe Exchange:**
DO NOT BILL INSURANCE

Scanned into patient's chart:

Signed Delivery Documentation form

Signed Diabetic Shoes Superbill

Physician Signature: _____ Date: _____

Witness Print: _____ Witness Signature: _____

Updated 09/18/2023