

**CERTIFICATE OF SHOE FITTING DELIVERY FORM  
 ACKNOWLEDGMENT OF RECEIPT OF WEARING INSTRUCTIONS  
 WARRANTY / GUARANTEE / RETURN MEDICARE REQUIRED SIGNED FORMS**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Medicare Number \_\_\_\_\_ Secondary Insurance Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

The above person has been fitted with the shoes and accommodative inserts listed below

**Instructions:** Enter the unit number for each product

For example, a pair of shoes is "2" in the A5500 box, 3 pairs of insoles is a "6" in the inserts box. If inserts are less than "6" indicate number and whether they are "L" for left and "R" for right.

_____ A5500 Shoes Manufacturer _____	_____ Size and Width _____	
_____ A5513 Custom Molded Inserts (if less than 6) _____	_____ Right _____	_____ Left _____
_____ A5512 Heat-Molded Inserts (if less than 6) _____	_____ Right _____	_____ Left _____
_____ L5000 Toe Filler Accommodations (indicate) _____	_____ Right _____	_____ Left _____
_____ Other (indicate code/description) _____	_____ Right _____	_____ Left _____

I acknowledge, understand and have received the following:

1. I have received the therapeutic shoes and custom or heat molded insoles in good condition.
2. The shoes and insoles have been properly fitted. If I received heat molded insoles, the insoles were heated with a heat gun and fit to my feet.
3. As the recipient, the parent or guardian of the recipient and/or the primary care giver of the recipient, I have received the following (check off each):

\_\_\_\_\_ A. Training and instruction regarding the proper use, care of my therapeutic footwear /inserts and when to change insoles.

\_\_\_\_\_ B. I understand if I am not happy with the fit of my shoes, \_\_\_\_\_ will attempt to refit or replace the shoe(s) and/or insert(s). All requests will be gladly accepted \_\_\_\_\_ days after receiving the shoe(s) and insole(s).

4. I acknowledge I have received the following forms (check off each)

\_\_\_\_\_ A. HIPAA \_\_\_\_\_ B. Supplier Standards \_\_\_\_\_ C. Patient's Rights and Responsibilities/Mission Statement

**I request that payment of Medicare, Medigap or any other private insurance be made to (Practitioner's Name) \_\_\_\_\_ for any services provided by the supplier.**

**I authorize any holder of medical information to release to the health care financing administration service. I permit a copy of this form to be used in place of the original. If my deductible has not been met with Medicare, or if my secondary insurance does not cover all or any part of the outstanding 20% that Medicare does not pay, I will be responsible for this amount.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

(If signature is other than the patient's please print the patient's name and relationship of the person signing below)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

**Attention Facility:** In signing this document, I certify (printed name of technician) , that I have assessed the patient's feet/foot and properly fit the patient for therapeutic footwear and accommodative insoles. I have given the patient all the necessary forms indicated on this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_