

## **Insurance Certification**

Date Called: \_\_\_\_/\_\_\_\_/\_\_\_\_

Contact Name: \_\_\_\_\_

Coverage in Effect? Yes No

Deductible? Yes No

Reset Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Amount: \$\_\_\_\_\_

Amount Met to Date: \$\_\_\_\_\_

Copay/Coinsurance? Yes No

Amount? \_\_\_\_\_

Policy Limits? \_\_\_\_\_

Dme Limits? \_\_\_\_\_

Foot Exclusions? \_\_\_\_\_

### **Specific coverages:**

Custom Molded Orthotics (L-3000): Yes No Amounts: \_\_\_\_\_

Diabetic Shoes (A5500, A5512): Yes No Amounts: \_\_\_\_\_

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