

Date: _____

Re: _____

Dear Dr. _____:

Physical examination revealed that your patient has the condition(s) listed on the enclosed form, and therefore qualifies for footwear and inserts under the Medicare Therapeutic Shoe Bill. This preventive program was established for at risk patients, with or without a history of foot ulceration. Medicare guidelines require that the physician who is managing the patient's diabetic condition certify the patient for footwear and inserts.

A copy of our office records are attached which verify the presence of the conditions indicated on the certifying physician statement. If you agree that the patient has the conditions indicated on the certifying statement, please sign and date the statement and return it to us by fax or mail. If you have any questions concerning this patient please do not hesitate to call. Thank you for your cooperation in this matter.

Sincerely,

<Physician Name>, D.P.M.