STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

PATIENT NAME: ____

HIC# ____________________________ (Patient's Medicare Number)

I certify that all of the following statements are true:

1) The patient has diabetes mellitus, ICD-9 code: ______________________

2) This patient has one or more of the following conditions. (Check all that apply):

- ☐ History of partial or complete amputation of the foot
- ☐ History of previous foot ulceration
- ☐ History of pre-ulcerative callus
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Foot deformity
- ☐ Poor circulation

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4) This patient needs special shoes and or inserts because of his/her diabetes.

5) Patient must be seen by Physician within 6 months prior to dispensing shoes & inserts.

Date patient was last seen _____________________________

I have reviewed, signed and dated a copy of the Podiatric medical records and agree that the patient has the qualifying foot conditions on this form.

Physician Signature: _____________________________Date ________________

Physician name (please print): ____
(Must be an M.D. or D.O.)

Address: ____

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NPI #________________________