Statement of Certifying Physician for Therapeutic Shoes

Date: _____

Patient Name: _____ SSN: _____

DOB: _____ Age: _____ YRS Medicare #: _____

Address _____

City _____State _____ Zip_____

I certify that all of the following statements are true:

1.) This patient has diabetes mellitus.
ICD 9 Code: 250.____ ____
(ICD-9-CM codes 250 – 250.91)

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

DX:

- ☐ Foot Deformity
- ☐ Peripheral Neuropathy w/ Callus Formation
- ☐ Poor Circulation
- ☐ Previous Amputation
- ☐ Previous Pre-ulcer Callus
- ☐ Previous Ulceration

RX:

- ☐ Customized/Custom Orthosis
- ☐ Custom-molded Shoes
- ☐ Depth Shoes
- ☐ Metatarsal Bar
- ☐ Offset Heel
- ☐ Rigid Rocker-bottom Sole or Bar
- ☐ Roller-bottom Sole or Bar
- ☐ Sole/Heel Wedge (Circle One)
- ☐ Other: _____

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

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

Physician Signature: _____ Date: _____

Physician Name (printed): _____ NPI #: _____

Primary Care Office Address: _____

_____

Primary Care Office Telephone #: _____