

# 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 #: \_\_\_\_\_