STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Name: _____

DOB: _____/_____/_____ HIC# _____
Patient's Medicare Number

I certify that all of the following statements are true:

1. The patient has diabetes mellitus, ICD-9 code: _____ Type 11 (non-insulin dependent)

   ICD-9 code: _____ Type 1 (insulin dependent)

2. The patient has one or more of the 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 443.9

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.

Physician Signature: _____, MD / DO Date: _____
(Circle One)

Physician name (please print): _____

Address: _____

City: _____ State: _____ Zip: _____

Physician NPI #: _____

(Please keep a copy in your records)