Statement of Certifying Physician for Therapeutic Shoes

Patient name:_____ HIC #:_____

I certify that all of the following statements are true:

This patient has diabetes mellitus.

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

A. History of partial or complete amputation of the foot
B. History of previous foot ulceration
C. History of pre-ulcerative callus
D. Peripheral neuropathy with evidence of callus formation
(There must be documentation of both the peripheral neuropathy of the legs and a callus)
E. Foot deformity
(The specific type of deformity [e.g., bunion, hammer toes, etc] must be documented)
F. Poor circulation
(There must be symptoms, signs, or a diagnosis of small or large vessel arterial insufficiency in the legs)

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

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

Shoes	Inserts
☐ Prefabricated Theraputic Shoe (A5500)	☐ Custom Molded (A5513
☐ Custom Fabricated Theraputic Shoe (A5501)	☐ Prefabricated (A5512)

Physician name (printed – must be M.D. or D.O.):

Physician Signature: _____ Date: _____

Physician NPI: _____