STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPUTIC SHOES

Patient Name :_____

Insurance Member ID :

_____

I certify that all the following statements are true:

1. This patient has diabetes mellitus.
2. 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
    e) Foot deformity
    f) Poor circulation
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) because of his/her diabetes.

Physician signature: _____
Date Signed: _____

Physician name (printed)_____
(Must be an M.D. Or D.O.)

Physician NPI: _____

Physician address:

_____

_____

_____

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