Statement of Certifying Physician for Therapeutic Shoes

Patient Name:____ D.O.B. ________________

I certify that all the following statements are true and correct:

1) **This patient has diabetes mellitus.** Please Circle One

a) Type 1 E10.40
w/o complications E10.9

b) Type 2 E11.40
w/o complication E11.9

c) Other ____________________

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**
Foot: LT: Z89.432 RT: Z89.431 **Great Toe:** LT:Z89.412 RT: Z89.411
Ankle: LT: Z89.442 RT: Z89.441 **Other Toe(s)**: LT: Z89.422 RT:Z89.421

b) **History of previous foot ulceration Z86.3**

c) **History of pre-ulcerative callus L84**

d) **Foot deformity**
Hammertoes: LT:M20.42 RT: M20.42 **Bunions**: LT:M20.12 RT:M20.11
Heel spurs: LT: M77.32 RT: M77.31

e) **Corns and callosities**-L84

f) **Poor circulation** I87.2

g) **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) because of his/her diabetes.**

I certify that I have thoroughly documented the patient's medical necessity for the product (s) ordered and will provide all required supporting documentation.

Physician Signature: ______________________________________

Date Signed: ______________________________________

Physician Name (printed): ______________________________________

Physician NPI: ______________________________________

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