Statement of Certifying Physician for Therapeutic Footwear

Patient Name: _____ HIC #: _____

Address: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. —ICD-9 Code: _____
   (ICD-9 diagnosis codes 250.00-250.93)

2. This patient has one or more of the following conditions *(check all that apply)*:

   ❑ History of partial or complete amputation of the foot

   ❑ Peripheral neuropathy with evidence of callus formation

   ❑ History of previous foot ulceration

   ❑ Foot deformity

   ❑ History of pre-ulcerative callus

   ❑ 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) and/or inserts because of his/her diabetes.

Certifying Physician Information

Signature: _____ Date: _____

Name: _____ DEA # _____

Medicare UPIN # _____ Medicaid Provider # _____

Prescription Form for Therapeutic Footwear

(Prescribing physician may be different from certifying physician.)

Patient Name: _____ HIC# : _____

Address: _____

Diagnosis: _____

Change to be effected: _____

Additional relevant information, such as systemic conditions or allergies to specific materials:

_____

Prescribing Physician Information

Signature: _____ Date: _____

Name: _____ DEA # _____

Medicare UPIN # _____ Medicaid Provider # _____