

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

Patient Name: _____

HIC#: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus ñ ICD-9 Code: _____
(ICD-9 diagnosis codes 250.00-250.91)
2. This patient has one or more of the following conditions (check all that apply):

DESCRIPTION

- History of partial or complete amputation of foot
- History of previous foot ulceration
- History of pre-ulcerative callus
- Peripheral neuropathy with evidence of callus formation
- Foot deformity
- 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.

Physician Signature: _____

Date Signed: _____

Physician Name (printed): _____

Physician Address: _____

Physician UPIN: _____