

Statement of Certifying Physician

For Therapeutic Shoes

Patient Name _____

1. The patient has Diabetes Mellitus. ___ 250.00 ___ 250.01
2. This patient has one or more of the following conditions.
___ History of partial or complete amputation of the foot. V49 ___ .71 Great toe,
___ .72 other toe, ___ .73 foot
___ History of previous foot ulceration. 707 ___ .14 heel to midfoot,
___ .15 other part of foot
___ History of pre-ulcerative callus. 700
___ Peripheral Neuropathy with evidence of callus formation. 337.1
___ Foot deformity 736.70
___ Poor circulation. 459.81
3. I am treating this patient under a comprehensive plan of care for their Diabetes.
4. This patient needs special shoes and inserts because of their diabetes.

I certify that all of the preceding checked statements are true.

Physician Signature _____ Date: _____

Physician Name (print) _____ UPIN _____
Note: must be an M.D. or D.O.

Address _____

City, State, Zip _____

Telephone _____