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 # ____________

Detach and reproduce for your practice

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:

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Prescribing Physician Information

Signature: ______________________ Date: ____________

Name: ______________________ DEA # ____________

Medicare UPIN # ____________ Medicaid Provider # ____________