

Statement of Certifying Physician

(The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician).

I certify that all of the following statements are true:

Patient Name: _____ Medicare #: _____

Address: _____

(City)

(State)

(Zip Code)

____ 1.) This patient has diabetes mellitus (ICD-9 Code): _____

(Applicable ICD-9 Range; 250.00-250.91)

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

____ History of partial or complete foot amputation ____ Foot deformity

____ History of pre-ulcerative callous ____ Poor circulation

____ Peripheral neuropathy w/callous formation ____ Previous ulcer(s)

____ 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) and/or inserts because of there diabetic condition.

Certifying Physician information:

Name (printed): _____

Signature: _____ DATE: ____/____/____ NPI: _____

Address _____

(City)

(State)

(Zip Code)

PHONE: (____) ____/____

Prescription Form for Therapeutic Footwear and Inserts

(Prescribing Physician may be an M.D., D.O., or D.P.M. and may be different from certifying physician).

Patient's Name: _____ Birthdate: ____/____/____

Diagnosis: _____

Purpose (desired effect): _____

Prescription: One Pair of Depth Shoes, Three Pairs of Multi-Density Inserts

Other: _____

Prescribing Physician Information:

Signature: _____ Date signed: ____/____/____

Name (printed): _____ NPI: _____

Please print out this form and bring it with you when you see your doctor.