

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

Patient Name: _____ Medicare #: _____

Telephone #: _____ Date of Birth: _____

I CERTIFY THAT THE FOLLOWING ARE TRUE:

1. This patient has diabetes mellitus. **ICD-9 CODE:** _____ (ICD-9 diagnosis codes 249.00-250.91)

2. This patient has one or more of the following conditions. **(CHECK ALL THAT APPLY)**

History of partial or complete
amputation of the foot

Foot Deformity

Poor Circulation

History of pre-ulcerative callus

Peripheral neuropathy with
evidence of callus formation

History of previous foot ulceration

**DOCTOR
TREATING
DIABETES**

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 **(MD OR DO SIGNATURE ONLY)**

(Per Medicare cannot be NPN, RN, or DPM)

Signature: _____ Date: _____

Print Name: _____ Telephone #: _____

Print Address: _____

NPI# _____

PRESCRIPTION FORM FOR THERAPEUTIC FOOTWEAR

(Prescribing physician may be different from certifying physician)

**Medical Doctor, Podiatrist
or Doctor Treating Diabetes**

Patient Name: _____ Medicare #: _____

Telephone #: _____ Date of Birth: _____

(RX) PLEASE CIRCLE ONE

1. One Pair of Diabetic Shoes / Three Pairs of Diabetic Inserts

2. One Pair of Custom Molded Diabetic Shoes / Two Extra Pairs of Inserts

3. Other (Please Explain): _____

PRESCRIBING PHYSICIAN INFORMATION

Signature: _____ Date: _____

Print Name: _____ Telephone #: _____

Print Address: _____

NPI# _____