Statement of Certifying Physician for Therapeutic Shoes

(Must be accompanied by last visit Progress notes)

Patient Name: _____ I certify that the following statements are true:

1 This Patient has Diabetes mellitus. 2. This Patient has one of the following conditions. **(Circle all that apply)**

a) History of partial of complete amputation of the foot. **(Must be stated in Doctor's notes)**

b) History of previous foot ulceration. **(Must be stated in Doctor's notes)**

c) History of pre-ulcerative callus. **(Must be stated in Doctor's notes)**

d) Peripheral neuropathy with evidence of **callous formation**. **(Must be stated in Doctor's notes)**

e) Foot deformity **(must identify and state in Doctor's notes i.e.: Bunion, Claw Toe, etc.)**

f) Poor Circulation **(must state in Doctor's notes i.e.: Tibial /Pedis pulse, Diminished etc.)**

3. I am treating this Patient under a comprehensive plan of care for his/her diabetes.

4. This Patient needs special shoes & multi-density inserts because of his/her diabetes. ICD code : _____

Physician signature: (MD or DO) _____ Date: _____

Physician name (print) : _____ NPI: _____

1410 Kings Hwy. N., Cherry Hill NJ 08034 **P: 856-428-2201 F: 856-428-2241**

PRESCRIPTION FOR THERAPEUTIC FOOTWEAR

Patient Name: _____ Date: _____

__ Extra Depth Diabetic Shoes (5500) – 1 pr. **__ Heat-Moldable Inserts (5512) – 3 pr.**

ICD Codes / Special Instructions: _____

Physician name: _____ Phone #: _____

Address: _____

Physician Signature: _____ **NPI**: _____

(Medicare allows one pr. of depth shoes and three pr. of multi-density heat molded inserts per calendar year.)

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