STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPUETIC SHOES FOR DIABETICS PROGRAM-

THIS DOCUMENT MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENTS SYSTEMIC DIABETIC CONDITION AND THE STATEMENTS DOCUMENTED BELOW MUST BE DOCUMENTED IN THE PATIENTS MEDICAL RECORD-WHICH WE MUST ALSO RECEIVE A COPY OF TO VERIFY THE ITEMS BELOW.

Patient Name: _____ ID #_____ D.O.B._____/_____/_____

I CERTIFY THAT ALL OF THE FOLLOWING STATEMENTS ARE TRUE:

1. This patient has Diabetes Mellitus ICD-10 Code: E _____ _____. _____ _____ _____

INSURANCE REQUIRES ICD-10 CODES TO BE INCLUDED IN PATIENT RECORD

2. This patient has one or more of the following conditions (PLEASE ADD ICD-10 THAT APPLY)

HISTORY OF PARTIAL OR COMPLETE AMPUTATION OF THE FOOT.	**_____ LOWER LIMB AMPUTATION, FOOT** **_____ LOWER LIMB AMPUTATION, GREAT TOE** **_____ LOWER LIMB AMPUTATION, LESSER TOE(S)**
HISTORY OF PREVIOUS FOOT ULCERATION.	**_____ ULCER OF HEEL AND MIDFOOT** **_____ ULCER OF OTHER PART OF FOOT**
HISTORY OF PRE-ULCERATIVE FOOT CALLUS.	**_____ HISTORY OF PRE-ULCERATIVE CALLUS**
PERIPHERAL NEUROPATHY AND EVIDENCE OF CALLUS FORMATION.	**_____ POLYNEUROPATHY IN DIABETES & HISTORY OF PRE-ULCERATIVE CALLUS BOTH MUST BE PRESENT**
FOOT DERFORMITY. **OTHER ICD-10:** **_____**	**_____ CLAW TOE** **_____ HAMMER TOE** **_____ HALLUX VALGUS** **_____ HALLUX RIGIDUS** **_____ UNSPECIFIED ACQUIRED DEFORMITY OF TOE** **_____ UNSPECIFIED DEFORMITY OF ANKLE & FOOT, ACQUIRED** **_____ CHARCOT ARTHOPATHY**
POOR CIRCULATION IN EITHER FOOT. **OTHER ICD-10:** **_____**	**_____ ARTHEROSCLEROSIS OF THE EXTREMETIES, UNSPECIFIED** **_____ ARTHEROSCLEROSIS OF THE EXTREMETIES, WITH INTERMITTENT CLAUDICATION** **_____ ATHEROSCLEROSIS OF THE EXTREMETIES, WITH ULCERATION** **_____ PERIPHERAL VASCULAR DISEASE, UNSPEC.**

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.

5. With diabetic footwear/insoles, the patient's prognosis is_____.

6. The above information is documented in the patient's medical record, as indicated in the attached clinical notes.

7. IF NO CONDITIONS APPLY PLEASE INDICATE HERE: _____.

CERTIFYING PHYSICIAN INFORMATION:

_____ M.D. OR D.O _____ _____/_____/_____

PHYSICIAN NAME (PRINTED) (CIRCLE ONE) PHYSICIAN SIGNATURE DATE

_____ _____

PHYSICIAN ADDRESS NPI #

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