Statement of Certifying Physician for Therapeutic Shoes and/or Foot Orthoses for Medicare Patients

This form must be completed by the M.D. or D.O. managing the patient's diabetic condition.

Patient's Name: ____________________________________ DOB: ___________________

This patient's feet were last examined by me on: ___________________________________

I certify that ALL of the following are true ***MUST CHOOSE ALL 3***

- ☐ This patient has diabetes mellitus.
- ☐ I am treating this patient under a comprehensive plan of care for his/her diabetes.
- ☐ This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

QUALIFYING CONDITIONS: (check all that apply)

I have diagnosed this patient and have included my notes showing that he/she has one or more of the following conditions:

- ☐ History of partial or complete amputation of the foot
- ☐ History of previous foot ulceration
- ☐ History of pre-ulcerative foot callus
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Foot deformity – specify: ____
- ☐ Poor circulation
- ☐ This patient has none of the above conditions

Physician's Signature: ____

Must be an M.D. or D.O.

Physician's Printed Name: ____

NPI#: ____________________________ Date: ____

Physician's Phone: ____

Physician's Address: ____

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PLEASE BE SURE TO INCLUDE THE CLINICAL NOTES FROM YOUR LAST DIABETIC EVALUATION APPOINTMENT