CERTIFICATION FORM

The physician managing the patient's diabetic condition must certify that the patient is under a comprehensive plan of care for diabetes and that special therapeutic shoes are needed due to his/her condition.

It is recommended that the following form be reviewed and signed by the certifying physician. The certifying physician must be an M.D. or D.O. and cannot be a podiatrist.

CERTIFICATE OF MEDICAL NECESSITY FOR THERAPEUTIC SHOES/INSERTS

Patient Information:

Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth _____

I certify that all of the following statements are true:

1. **This patient has diabetes mellitus** (ICD-9 diagnostic codes 250.00 - 250.93): (Check one)

   _____ Insulin Dependent _____ Non-Insulin Dependent

2. **This patient has one or more of the following conditions** (Check all that apply):
   - _____ History of partial or complete foot amputation
   - _____ History of previous foot ulceration
   - _____ History of pre-ulcerative callus
   - _____ Peripheral neuropathy with evidence of callus formation
   - _____ Foot deformity
   - _____ Poor circulation

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

4. **This patient needs special shoes (depth) and/or orthotics insoles because of his/her diabetes.**

Physician Signature (**M.D. or D.O.) _____ Address _____

Physician's Printed Name _____ City, State, Zip _____

Date _____ UPIN# _____ Phone _____

Fed Tax ID #_____

***Certifying physician must be a M.D. or D.O.*