

PLEASE RETURN TO _____

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

*NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM—**THIS DOCUMENT MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION AND THE STATEMENTS DOCUMENTED BELOW MUST BE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD.** THIS SCP MUST BE ACCOMPANIED BY A SIGNED DIABETIC FOOTWEAR PRESCRIPTION FORM.*

Patient: _____

Medicare #: _____

I certify that all of the following statements are true:

- 1) This patient has diabetes mellitus- ICD-9 Code: **250.** ____ ____ (**Five digit ICD-9 Diagnosis Code Required 250.00-250.93**)
- 2) This patient has one or more of the following conditions (**circle all that apply**):
 - a) History of partial or complete amputation of the foot.
 - b) History of previous foot ulceration.
 - c) History of pre-ulcerative callus.
 - d) Peripheral neuropathy with evidence of callus formation.
 - e) Foot deformity.
 - f) 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 or custom-molded shoes) and/or inserts because of his/her diabetes.
- 5) **The above information is documented in the patient's medical record.**

CERTIFYING PHYSICIAN INFORMATION:

Physician Name (printed)	MD or DO <small>(circle one)</small>	Physician Signature	Date
Physician Address		Physician UPIN #	
		Physician Phone #	

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