

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—WHICH WE MUST ALSO RECEIVE A COPY OF TO VERIFY THE ITEMS BELOW. THIS SCP MUST BE ACCOMPANIED BY A SIGNED DIABETIC FOOTWEAR PRESCRIPTION FORM.

Patient Name: _____

I certify that all of the following statements are true:

- 1) This patient has diabetes mellitus- ICD-9 Code: 2_____. _____ (Five digit ICD-9 Diagnosis Code Required 249.00-250.93)
- 2) This patient has **one or more** of the following conditions (check all that apply):

History of partial or complete amputation of the foot.	<input type="checkbox"/> Lower limb amputation, foot (V49.73 & 755.38) <input type="checkbox"/> Lower limb amputation, great toe (V49.71 & 755.39) <input type="checkbox"/> Lower limb amputation, lesser toe(s) (V49.72 & 755.39)
History of previous foot ulceration.	<input type="checkbox"/> Ulcer of heel and midfoot (707.14) <input type="checkbox"/> Ulcer other part of foot (707.15)
History of pre-ulcerative foot callus.	<input type="checkbox"/> History of pre-ulcerative callus (707.9)
Peripheral neuropathy <u>and</u> evidence of callus formation.	<input type="checkbox"/> Polyneuropathy in diabetes (357.2) <u>and</u> History of pre-ulcerative callus (707.9)
Foot deformity. Other ICD-9: _____	<input type="checkbox"/> Claw toe (735.5) <input type="checkbox"/> Hammer toe (735.4) <input type="checkbox"/> Hallux valgus (735.0) <input type="checkbox"/> Hallux rigidus (735.2) <input type="checkbox"/> Unspecified acquired deformity of toe (735.9) <input type="checkbox"/> Unspecified deformity of ankle and foot, acquired (736.70) <input type="checkbox"/> Charcot Arthropathy (713.5)
Poor circulation in either foot. Other ICD-9: _____	<input type="checkbox"/> Atherosclerosis of the extremities, unspecified (440.20) <input type="checkbox"/> Atherosclerosis of the extremities with intermittent claudication (440.21) <input type="checkbox"/> Atherosclerosis of the extremities with ulceration (440.23) <input type="checkbox"/> Peripheral vascular disease, unspecified (443.9)

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

CERTIFYING PHYSICIAN INFORMATION:

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

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