

STATEMENT OF CERTIFYING PHYSICIAN
THERAPUTIC SHOES FOR DIABETICS

For Therapeutic Shoes for Persons with Diabetes to be covered by Medicare, the patient's medical record must contain sufficient information about the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).

Instructions: Please complete as accurately as possible, and sign below to confirm patient's need for therapeutic shoes/insoles.

Patient Name: _____ Date of Birth: _____

Address: _____
City State Zip Code

Medicare/HIC# _____ Phone () _____

I certify that the following statements are true:

1. This patient has diabetes mellitus. ICD-9 code: 250. _____
2. This patient has one or more of the following conditions: (please check all that apply)
 - a. History of partial or complete amputation of the foot; **and/or**
 - b. History of previous foot ulceration; **and/or**
 - c. History of pre-ulceration callus; **and/or**
 - d. Peripheral Neuropathy with evidence of callus formation; **and/or**
 - e. Foot Deformity; **and/or**
 - f. Poor Circulation.
3. Not only am I treating this patient under a comprehensive plan of care for his/her diabetes but I also recently saw said patient in-office on _____ (Date of Service). Their stated diagnoses have been personally documented by me in their file.
4. This patient needs special shoes (depth or custom molded shoes) and insert(s) because of his/her diabetes.

Physician Signature (MD or DO): _____ Date: _____

Physician Name (*printed*): _____ NPI#: _____

Phone: () _____ Fax () _____

Doctor's Order

Instructions: Please complete as accurately as possible, and sign below to confirm patient's need for therapeutic shoes/insoles.

Please provide the above named patient with the following: (Circle one of the below)

1. One pair of therapeutic off-the-shelf depth-inlay shoes with three pairs heat molded multi-density insert(s) **OR**
2. One pair of therapeutic off-the-shelf depth-inlay shoes with three pairs custom molded multi-density insert(s) **OR**
3. One pair of custom therapeutic shoes molded from a cast(s) of the patient's feet with two pairs custom molded multi-density Inserts(s).

Date of Last Office Visit: _____

Doctor's comments: _____

By signing below, all of the information contained in this statement is true and accurate to the best of my knowledge:

Physician Signature (MD or DO): _____ Date _____

Physician Name (*Printed*): _____ NPI# _____ Phone () _____

Note to Physician: The Comprehensive Error Rate (CERT) Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), performs medical review for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided to Medicare Beneficiaries to determine paid claims error rates for Medicare contractors and providers. It is your responsibility as the ordering physician to determine and document the medical need for all healthcare services. The CERT contractor may request that the supplier obtain this information from you in order to verify that Medicare coverage criteria have been met.

Please fax this form to:
(562) 490-2831