Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

MBI #: _____

I certify that all of the following statements are true:

1. This patient has Diabetes Mellitus: _____ (ICD-10-CM codes Ell.*)
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) because of his/her diabetes.

☐ I agree with the foot examination performed by the DPM.

Physician Signature: _____

Date signed: _____

Physician Name (Print) -**MUST BE AN M.D. OR A D.O.:**

_____

Physician Address: _____

_____

_____

Physician NPI: _____