

# STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES/INSERTS

It has been demonstrated that diabetic foot complications can be significantly reduced through appropriate management and prevention programs. One aspect of this management is choosing appropriate foot wear and where needed, protective shoe inserts. Under the Medicare Therapeutic Shoe Bill, at risk diabetics can qualify for this service. The best management of diabetic foot problems occurs when the physician (MD or DO) caring for the patient's diabetes and your podiatrist are working together to minimize foot problems. The MD or DO must sign this form as the Certifying Physician. The Prescribing Physician (a podiatrist or other qualified physician) may provide the patient with a footwear prescription.

**Patient Name** \_\_\_\_\_

I certify that all of the following statements are true

1. This patient has diabetes mellitus
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.

PHYSICIAN NAME: \_\_\_\_\_ M.D or D.O Date: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN NPI #: \_\_\_\_\_ PHYSICIAN PHONE: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

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