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**Statement of Certifying Physician for Diabetic/Therapeutic Shoes**  
(MD or DO Only)

<b>Patient Name:</b>		<b>DOB:</b>	
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**Directions: All fields are required by the payer to be completed by the certifying physician. Foot Exams not completed by the Certifying Physician should have been reviewed, countersigned, initialed, dated & agreement stated prior to or on the same date as the completion of this form. Do not complete this form if you have not completed this step.**

I certify that all of the following statements are true:

- 1) This patient has diabetes mellitus. ICD-10 Code: \_\_\_\_\_
- 2) This patient has one or more of the following conditions documented: (check all that apply)
  - History of partial or complete amputation of the foot
  - History of previous foot ulceration
  - History of pre-ulcerative callus
  - Peripheral neuropathy with evidence of callus formation (Peripheral neuropathy alone does not qualify) of either foot
  - Foot deformity
  - Poor circulation
- 3) Within the past 6 months, an exam has been performed, and qualifying conditions have been documented.
- 4) I am treating this patient under a comprehensive plan and care for his/her diabetes.
- 5) This patient needs therapeutic shoes (extra depth or double depth) and/or inserts because of his/her diabetic condition.
- 6) If applicable, I have read the prescribing practitioners information documented in this patients medical record and agree with service(s) that has/have been prescribed.

**Certifying Physician Information (must be a M.D. or D.O.)**

Name (Printed): \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*(Rubber/Stamped Signatures are not permitted)*

**Fax completed form with all documentation to (910) 755 -6769 Or E-Fax (910) 230 –5616.**