plor.net

PROSTHETIC LABORATORIES

Statement of Certifying Physician for Therapeutic Footwear

Please complete all areas

Patient Name _____ Date _____

Patient's Medicare # _____ DOB _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. *(ICD-9 Diagnosis Code(s) 249.00 - 250.93 - 4th or 5th digits must apply.)*

   DX Code: _____-_____ DX Code: _____-_____ DX Code: _____-_____ DX Code: _____-_____

2. This patient has one or more of the following conditions *(Circle all that apply):*

   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy with evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation in either foot; and

3. I am treating this patient under a comprehensive plan of care for his/her diabetes, and

4. This patient needs special shoes *(depth or custom molded shoes)* and/or custom molded inserts with arch supports due to his/her diabetes and/or further prevention of potential ulceration.

Physician Signature _____

Date Signed _____ NPI # _____

Physician's Printed Name (Must be MD or DO) _____

Physician's Complete Address _____

City _____ State _____ Zip _____