J.T. MURDOCH *A Shoe Fitting Tradition Since 1888*

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Statement of Certifying Physician for Therapeutic Footwear

Patient Name:_____ Date of Birth:_____

I certify that the following 4 statements are true:

1. This patient has diabetes mellitus. Diagnosis code: _____
2. This patient has one or more of the following foot conditions:
   (**check all that apply**)
   - ____ History of partial or complete foot amputation
   - ____ History of pre-ulcerative callous
   - ____ Peripheral neuropathy with callus formation
   - ____ Foot deformity
   - ____ Poor circulation
   - ____ Previous ulcer(s)

   NOTE: Any condition checked above needs to be clearly stated in the patient's medical records
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) and inserts because of his/her diabetic condition

Certifying Physician Information

Note: This form, and the supporting clinical notes, must be authored by the **MD or DO** caring for the patient's diabetes. Medicare will not accept it from a DPM, PA or APN.

Name (printed):_____ NPI#_____
Address:_____

By signing this form, I agree I have performed an in person evaluation of this patient and that the clinical notes documented during that visit meet the clinical note guidelines below.

Signature:_____ Date:_____

Clinical Note Guidelines (must be met for Medicare to cover diabetic footwear)

a. Must explicitly state that your patient has diabetes and assign a 5 digit ICD code
b. Must explicitly demonstrate evidence you are treating the patient under a comprehensive plan of care for diabetes. Elaborate on portions of the plan: test results, exams, medicine, nutrition, etc
c. Must explicitly state "The patient would benefit from diabetic footwear to protect their feet"
d. Must explicitly document a foot exam, **and** most importantly, document evidence that the foot condition(s) checked above under #2 exist.
e. Must be signed by the certifying physician (MD or DO).