**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 \_\_\_\_ Foot deformity

\_\_\_\_ History of pre-ulcerative callous \_\_\_\_ Poor circulation

\_\_\_\_ Peripheral neuropathy with callus formation \_\_\_\_ Previous ulcer(s)

**NOTE**: Any condition checked above needs to be clearly stated in the patient’s   
 medical records

1. I am treating this patient under a comprehensive plan of care for his/her diabetes
2. 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)

1. Must explicitly state that your patient has diabetes and assign a 5 digit ICD code
2. 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
3. Must explicitly state “The patient would benefit from diabetic footwear to protect their feet”
4. Must explicitly document a foot exam, **and** most importantly, document evidence that the foot condition(s) checked above under #2 exist.
5. Must be signed by the certifying physician (MD or DO).