

*Please have your Doctor fill out this form and **FAX to 248-449-7307**



43035 Grand River Novi, MI 48375
Phone: 248-443-5300 • Fax 248-449-7307

Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

D.O.B. _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus (please check one)

_____ 250.01 Type I

_____ 250.00 Type II

2. This patient has one or more of the following conditions. (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

_____ Foot deformity

_____ 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.



Diabetes mellitus (ICD-9 code 250.00-250.91)



_____ Extra-depth shoes and inserts

_____ Ankle gauntlet

Physicians Name: _____ NPI # _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

I certify active treatment of this patient. This equipment is part of my course of treatment and is "reasonably and medically necessary" and is not a convenience item. To my knowledge, the above information is accurate.

X _____
PHYSICIANS SIGNATURE

NPI #

Date