

Dear Doctor;

This patient states that he/she is under your care for diabetes. As you know, diabetics are prone to foot problems, many of which could be prevented with proper shoes. I believe this patient can benefit from extra depth/custom shoes with dual density, full contact inserts. Please take a moment to complete, sign and return this form, so that Medicare will pay 80% of the approved costs. With your help, this patient will be able to get proper shoes and may be able to prevent foot ulcers and amputations.

Statement of Certifying Physician for Therapeutic Footwear

Patient Name _____

I certify that:

1. This patient has diabetes mellitus. – ICD-9 Code: _____
(ICD-9 diagnosis codes 250.00-250.91)

2. This patient needs therapeutic shoes and inserts because of his/her diabetes and has one or more of the following conditions:

 ___ History of partial or complete amputation of the foot
 ___ History of previous foot ulceration
 ___ History of pre-ulcerative callus
 ___ Callus formation with peripheral neuropathy
 ___ Foot deformity (bunion, hammertoe, etc...)
 ___ Poor circulation

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

Certifying Physician Information (Please fill in all of the following blanks)

Signature: _____ Date: _____

Name: _____

Medicare UPIN # _____

****PLEASE MAIL THIS FORM TO:****
Huntington Foot & Ankle Clinic, Inc.
2735 5th Ave.
Huntington, WV 25702