DIABETIC SHOE CLINIC

Certificate of Medical Necessity

Patient Name _____ Date of Birth _____

I Certify that all the following statements are true

1: This Patient has diabetes mellitus- Please check one from each column

[ ] Type 1 Diabetic [ ] Controlled
[ ] Type 2 Diabetic [ ] Uncontrolled

2: This Patient has one or more of the following conditions

[ ] History of partial or complete amputation of the foot
[ ] Peripheral neuropathy w/evidence of callus formation
[ ] History of previous foot ulceration
[ ] Foot Deformity
[ ] History of pre-ulcerative callus
[ ] Poor circulation

3:Within the past 3 months an exam has been preformed and qualifying condition(s) have been documented

4:I am treating this patient under a comprehensive plan and care for his/her diabetes. DATE LAST SEEN:_____

5:This patient needs special shoes (depth or custom-molded) and/or inserts because of their diabetic condition

(M.D. or D.O. ONLY, No Stamps)

Physician Name:_____

Phone:_____ Fax:_____

NPI:_____ Date:_____

Address:_____

Physician Signature:_____

Office: +1(888)470-5593 | Fax: (859)545-4989

DIABETIC SHOE CLINIC

Prescription for Therapeutic Shoes & Inserts

Patient Name _____ Date of Birth _____

Primary Diagnosis:_____

Secondary Diagnosis:_____

Pertains to: [ ]Left Foot [ ]Right Foot [ ]Both Feet

RX:

Shoes

[ ] Extra Depth Therapeutic Shoes (A5500)-One Pair

Inserts

[ ] Custom Fabricated (A5513)- Three Pair
[ ] Heat Molded Inserts (A5512)- Three Pair
[ ] Partial Foot Prosthetic Insert(L5000)- One for:[ ]Left[ ]Right

Physician Name:_____

Phone:_____ Fax:_____

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Physician Signature:_____

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