The Shoe Smith, L.L.C.

Advanced Pedorthic Specialists

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

Patient Telephone:_____**Patient Date of Birth:**_____

I certify that all of the following are true:

1. This is a patient with diabetes mellitus — **ICD-9 Code:**_____

(ICD-9 diagnosis codes 250.00-250.91)

- 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 or her diabetes.
- 4. This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.
- 5. This Patient is_____insulin dependant/ _____non-insulin dependent.

Certifying Physician Information

Signature:_____**Date:**_____

Physician Name (Printed-MUST BE AN M.D. OR D.O.):

_____

Physician address:_____

_____

Physician NPI #:_____

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