Foot Solutions of Hickory
242 Union Square NW
Hickory, NC 28601
Telephone: 828-328-9844 Fax: 828-324-4059
Email: Hickory@footsolutions.com

Statement of Certifying Physician for Therapeutic Shoes and Inserts

This Statement of Certifying Physician is required by law under the Social Security Act in order for your patient to receive their therapeutic shoes and inserts. Please return this Statement of Certifying Physician along with your medical records of the most recent diabetic evaluation and comprehensive diabetic foot exam detailing the patient's foot condition. Please see the accompanying fact sheet to assist you in documenting the patient's qualifying condition.

Medicare does not consider the Statement of Certifying Physician to be part of the medical records. Descriptions of the patient's foot examination and the patient's qualifying foot condition must be contained in the medical records.

Name ____________________ Address ____________________

Phone __________ Date of Birth __________ City __________ State __________ Zip __________

HCIN ____________________

The date of the patient's most recent office visit for their diabetic evaluation and comprehensive diabetic foot exam was: __________

(Must be within 6 months of the date the patient is provided their diabetic shoes and/or inserts. The medical notes for the office visit noted above must be attached to this Statement of Certifying Physician)

I certify all of the following statements are true: (Please check all that apply)

- ☐ 1. The patient has diabetes mellitus.
- 2. The patient has one or more of the following conditions
  - ☐ a) History of partial or complete amputation of the foot
  - ☐ b) History of previous foot ulceration
  - ☐ c) History of pre-ulcerative callus
  - ☐ d) Peripheral Neuropathy with evidence of callus formation (Do not check if patient **does not** have calluses)
  - ☐ e) Foot Deformity(Description must be in the medical notes)
  - ☐ f) 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.

Certifying Physician Name (Printed) ____________________

Certifying Physician Signature ____________________ Date Signed: __________

NPI ____________________

Note: Physician signature and date must be handwritten. No Signature/date stamps are permissible. Date must not be more than 3 months from the date the patient is provided their diabetic shoes and/or inserts.

Physician Address: ____________________

City: __________ State: __________ Zip: __________

Telephone: __________ Fax: __________ Email: __________

The Statement of Certifying Physician may only be signed by a M.D. or D.O. Statements signed by a D.P.M., N.P., C.N.A., M.A. are not allowable and will render the Statement void.

Please Fax with Medical Records to: 828-324-4059