Foot Solutions of Reading
654 B Philadelphia Ave
Shillington, PA 19607
Phone: 610-775-4950
Fax: 610-775-4951
Reading@footsolutions.com

Statement of Certifying Physician for Therapeutic Shoes and Inserts

Valid for 3 months from date of signature

PATIENT____DOB_____________

PHYSICIAN (PRINT)____NPI______________

PHYSICIAN ADDRESS____

PHONE____FAX__________________________________

I certify all the following statements are true:

1. This patient has diabetes mellitus
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 **MUST** document callus formation.
- ☐ Foot Deformity = HAV, tailors bunions, hammertoes, mallet toes, overlapping toes, pes planus, pes cavus, charcot,
- ☐ Poor Circulation = PAD, PVD, venous insufficiency, ischemic vascular disease.

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) because of his/her diabetes

PHYSICIAN SIGNATURE____DATE SIGNED____________

The Statement of Certifying Physician may only be signed by an MD or DO. Statements signed by a DPM, NP, CNA, or MA are not allowed by Medicare.

PLEASE INCLUDE THE OFFICE VISIT NOTES WHEN FAXING THE SCP.
Patient MUST SEE an MD or DO. Diabetic exams cannot be performed by a DPM, NP, CRNP, CNA, or MA.

Please fax this form with the patient's medical records to 610-775-4951.