

Therapeutic Shoes and Inserts

Foot Solutions Greenville

103 E. Butler Road Ste. K
Greenville SC 29662



TSB Medical Compliance

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Statement of Certifying Physician

Valid for 3 months from date of signature

Patient Name (Print):

DOB:

Physician MD/DO:

NPI:

Physician Address:

Phone:

Fax:

I certify all of 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 with evidence of callus
formation

Foot Deformity

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.

PHYSICIAN SIGNATURE:

DATE:

The Statement of Certifying Physician may only be signed by a M.D. or D.O