Diabetic Shoes and Inserts

Foot Solutions East Cobb
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Marietta GA 30062

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Statement of Certifying Physician

Valid for 3 months from date of signature

Patient Name: **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. Statements signed by a D.P.M., N.P.C.N.A., M.A. are not allowed by Medicare