Foot Solutions East Cobb
4101 Roswell Road
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Marietta GA 30062
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Statement of Certifying Physician for Therapeutic Shoes and Inserts

This Statement of Certifying Physician is required by law under the Social Security Act.

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 diabetic evaluation to include foot exam : _____

(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 form)

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 FNP or PA Name (Printed) _____ Date Signed _____

Certifying FNP or PA Signature _____ NPI: _____

Supervising Physician Name (Printed) _____ Date Signed _____

Supervising Physician Signature _____ 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: _____

Please Fax with Medical Records to: 914.618.4599