



STATEMENT OF CERTIFYING PHYSICIAN for Therapeutic Shoes

I am writing to request you complete the Statement of Certifying Physician below for the patient listed so that we may provide them with therapeutic shoes and inserts. In order to qualify for Medicare reimbursement, your certification that they meet the conditions listed below is required. Per Medicare:

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed below is present. If requested by the supplier, you must provide copies of those records. (Robert D. Hoover, Jr., MD, MPH, FACP, Medicare Director, CIGNA, Jurisdiction C, February 2009)

Patient: _____ DOB: _____

1. This patient has diabetes mellitus: Type II Type I (ICD-10 Code(s): _____)

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 for care of his/her diabetes and the date of their last office visit during which we addressed their diabetes management was: _____

4. This patient needs special shoes (depth or custom-molded) because of his/her diabetes.

5. This patient needs shoe inserts (heat-molded or custom fabricated) because of his/her diabetes.

Physician Signature: _____ Date: _____

Physician Name: _____ NPI #: _____

Physician Address: _____

PLEASE FAX BACK TO:
West Springfield Office (413) 785-4048 or Bloomfield Office (860) 904-2149