Statement of Certifying Physician for Therapeutic Footwear

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certifying Physician Information (Must be an MD or DO)**

Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DEA#\_\_\_\_\_\_\_\_\_\_\_ NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the following statements are true (Must be completed in full):

**1.**This patient has diabetes mellitus-**ICD-10 Code=\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must be diagnosis code E08.00-E13.9**); and

**2.**I have documented in the beneficiary’s medical record**\*\*** one or more of the following conditions:

a. Previous amputation of the other foot, or part of either foot, or

b. History of previous foot ulceration of either foot, or

c. History of pre-ulcerative calluses of either foot, or

d. Peripheral neuropathy **with evidence of callus formation**

**(Peripheral neuropathy alone does not qualify)** of either foot, or

e. Foot deformity of either foot, or

f. Poor circulation in either foot; and

 **3.**I am treating this patient under a comprehensive plan for his/her diabetes.

**4.**This patient needs special footwear (depth or custom molded) and/or inserts because of his/her diabetes.

**5.This patient had an in-person visit within 6 months prior to this date. \*\***

**6.Documentation attesting to all conditions checked above is included in this return facsimile.\*\***

**7.****If applicable, I have read the prescribing practitioners information documented in this**

**patients medical record and agree with service(s) that has/have been prescribed.**

**\*To meet Medicare guidelines the certifying physician signature cannot be a rubber signature**

**stamp nor signed and initialed by anyone else. The printed name, signature, and date are**

**of the utmost importance.**

**\*\*To meet Medicare guidelines for the beneficiary’s medical record documentation it must be**

**from the records of the M.D. or D.O. who is treating the patient’s diabetes and must be no older**

**than 6 months prior to the signing of this statement.**

Physician, complete form and return to:**\_\_\_\_\_\_\_\_\_\_** at Heel to Toe, Inc. 106 West Main Street, Urbana, Illinois 61801

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