Statement of Certifying Physician for Therapeutic Shoes

Patient_____DOB_____Date Ordered: _____

When completing this form, please make certain that the following checked conditions(s) are the same as your determined diagnosis indicated on the Physician Notes on Qualifying Condition.

This patient has Diabetes Mellitus:

☐ Type II ☐ Type I

Qualifying Conditions (must be documented in medical records)

- ☐ History of partial or complete amputation of the foot
- ☐ History of previous foot ulceration
- ☐ History or pre-ulcerative callus
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Poor Circulation
- ☐ Foot Deformity-
  - ☐ Bunion
  - ☐ Claw Toe
  - ☐ Hallux Rigidus
  - ☐ Hallux Valgus
  - ☐ Hammer Toe
  - ☐ Unspecified deformity of ankle and foot; acquired
  - ☐ Unspecified deformity of toe

Prescription for Diabetic Shoes and Inserts

☐ Extra Depth (A5500) - 1 pair, Shoes ☐ Heat Moldable (A5512)-3pair Inserts or ☐ Custom Inserts (K0903)-3pair

*Shoes require inserts, please choose 1 insert option.

Acknowledgement of Statement:

I am managing and treating this patient's diabetes under a comprehensive plan of care. This patient requires diabetic shoes and heat-molded or custom –molded inserts to help prevent ulcers and further complications

Physician Signature _____ Date _____
No Stamp Signature Allowed

Physician Name (printed)_____NPI _____
Must be the MD or DO who is actively treating the patient's diabetes

Physician Address _____

Physician Phone_____ Physician Fax _____

Please fill out this form entirely; sign and fax back to Medical Arts Pharmacy @ 325.942.0761
Medical Records MUST document the condition marked above, please forward the Face to Face along with this order