STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Name : DOB :

1) The patient has **DIABETES MELLITUS** (ICD-10) diagnosis codes E.9-E10.65); and

2) **The patient has one or more of the following conditions:**

Yes ☐ No ☐	a) History of partial or complete amputation of the foot.
Yes ☐ No ☐	b) History of previous foot ulceration.
Yes ☐ No ☐	c) History of pre-ulcerative callus.
Yes ☐ No ☐	d) Peripheral neuropathy with evidence of callus formation.
Yes ☐ No ☐	e) Foot deformity.
Yes ☐ No ☐	f) Poor circulation.

3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs diabetic shoes.

I certify that all of the preceding statements are true.

Progress note must be attached to this form: Patient's medical record must contain sufficient documentation of the patient's medical condition to support the need for the type and quantity of items ordered. The information should include the patient's diagnosis and other pertinent information, such as duration of the patient's theraupeutic interventions and results, past experience with related items etc. For selected claims, the DME MAC may request that the supplier obtain this information from you so that the DME MAC can verify that Medicare coverage criteria have been met.

Physician signature: _____ **Date :** _____

Note: Must be an MD. or DO / No stamp signature / no stamp date

Physician Name :

NPI: **Phone :**

Address :

PAUL'S SHOES

1102 S. GLENDALE AVE.
GLENDALE, CA. 91205
TEL: (818)507-0314
FAX:(323)389-0999

MILANO SHOES

5207 W. SUNSET BLVD.
LOS ANGELES, CA. 90027
TEL: (323)661-8004
FAX:(323)389-0999

DOCTOR ORDER THERAPEUTIC SHOES FOR DIABETICS

Instructions: Please make any necessary changes to reflect the patient's status, initial any changes and sign below to confirm the patient's need for therapeutic shoes.

Patient Name : _____

MBI # : **DOB :** _____

Please provide the above named patient with following:

1) One pair of therapeutic shoes , manufactured to accomodate multi-density inserts.
2) Three pairs of multi-density inserts for therapeutic shoes.
3)

Physician signature: _____ **Date :** _____

Note: No stamp signature / no stamp date

Physician Name : _____

NPI: **Phone :** _____

Address : _____

Fax : _____

PAUL'S SHOES

1102 S. GLENDALE AVE.
GLENDALE, CA. 91205
TEL: (818)507-0314
FAX:(323)389-0999

MILANO SHOES

5207 W. SUNSET BLVD.
LOS ANGELES, CA. 90027
TEL: (323)661-8004
FAX:(323)389-0999