STATEMENT OF CERTIFYING PHYISICIAN THERAPEUTIC SHOES
Can be signed by M.D. or D.O. ONLY

Patient's Name: ______________________________________ D.O.B. ___/____/____

Address: _____________________________________ City: _______________________

State: ____________, Zip Code: ___________, Phone: (______)____________________

Medicare Number: ____________________________

ICD10 Codes for this PATIENT: ____

I CERTIFY THAT ALL OF THE STATEMENTS ARE TRUE & DOCUMENTED IN THIS PATIENT'S PROGRESS NOTES

1. **This patient has diabetes mellitus.** **ICD10 Codes: ____________________**
2. **This patient has one or more of the following conditions: (Please Circle)**

Must Fill IN

a. History of partial or complete amputation of the foot. ICD10 ______
b. History of previous foot ulceration. ICD10 ______
c. History of pre-ulcerative callous formation. ICD10 ______
d. Peripheral neuropathy with evidence of callous formation. ICD10 ______
e. Foot deformity. ICD10 ______
f. Poor or impaired circulation. ICD10 ______
g. Diabetic ulceration. ICD10 ______
h. Other, please specify _______________ ICD10 ______

3. **I am treating this patient under a comprehensive plan of care for his/her diabetes and he/she is ____ insulin dependent/ ____ non-insulin dependent; and**
4. **This patient needs special shoes and inserts because of his/her diabetes.**

Certifying Physician's Information:

Name: ________________________________ Signature: _________________________

Address: ____________________________ City: _________________________________

State: _________, Zip Code: ______________ NPI: ______________________________

Please redeem at: **Michelangelo's Foot Comfort & Pedorthic Shoppe**
www.PedorthicSolutions.com
8344 W. Lawrence Ave.
Norridge, Illinois 60706-3152
Tel. 708-453-4900; Fax 708-453-3338

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