Evergreen
Prosthetics & Orthotics

Emanuel · Good Samaritan · St. Vincent's · Portland Central · Portland East · Hillsboro · Oregon City · Vancouver · Longview · Spokane · Tillamook · Astoria

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

Patient Name: _____ Date of Birth: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD-9 Code: _____
(ICD-10 Diagnosis Code Required E08.00 - E13.9)

2. This patient has one or more of the following conditions (check all that apply):

   A. History of particular or complete amputation of the foot
   B. History of previous foot ulceration
   C. History of pre-ulcerative callus
   D. Peripheral neuropathy with evidence of callus formation
   E. Foot deformity
   F. Poor circulation (If checked, must also have another condition marked)

3. Not only am I treating this patient under a comprehensive plan of care for Diabetes, but I also recently saw this patient in-person on ___ / ___ /____. Their staged diagnosis has been personally documented by me in their file.

4. This patient needs special footwear (depth or custom molded and/or inserts because of their diabetic condition.

5. The above information is documented in the patient's medical record, **as indicated in the attached clinical notes.**

Signature (M.D. or D.O.): _____ Date: _____

**** PA-C's or ARNP's are not eligible to sign this form per Medicare guidelines for Therapeutic Shoes ****

Physician Name: _____ NPI#: _____

Phone: _____ Fax: _____