Certificate of Medical Necessity

For Prescription Diabetic Shoes and Inserts

Patients Name _____

HIC#: _____ **D.O.B.** _____ **Phone** _____

I certify that all of the following statements are true:

1. **This patient has diabetes mellitus – ICD-9 (ICD-9 diagnosis codes 250.00 – 250.91)**

   - ☐ **250.01 Type I IDDM (Insulin injections dependent)**
   - ☐ **250.00 Type II NIDDM (treated by Pills, Diet and/or Insulin injections)**

   Other Code:_____

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

   - ☐ **History of partial or complete amputation of the foot or leg**
   - ☐ **History of previous foot ulceration**
   - ☐ **History of pre-ulcerative callus**
   - ☐ **Peripheral Neuropathy with evidence of callus formation**
   - ☐ **Poor Circulation**
   - ☐ **Foot deformity (Corns, Calluses, Hammer toes, Bunions, etc…)**

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

4. **This Patient needs prescription diabetic shoes with inserts because of his/her diabetes.**

_____

Physician's Name _____ **NPI** _____

Address_____

City _____ **State** _____

Zip_____**Phone** _____ **Fax** _____

I certify active treatment of this patient. This equipment is part of my course of treatment and is "reasonably and medically necessary", and is not a convenience item. To my knowledge, the above information is accurate.

Physician's Signature: _____ **Date** _____