Therapeutic Shoes for Persons with Diabetes Statement of Certifying Physician (TRX)

Patient Information:

Last Name:_____ First Name: _____ MI: _____

D.O.B. : _____ Gender: M/F Phone #:_____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus
2. This patient has one or more of the following conditions (Check all that apply):
   a. ____History of partial or complete amputation of foot
   b. ____History of previous foot ulceration
   c. ____History of pre-ulcerative callus
   d. ____Peripheral neuropathy with evidence of callus formation
   e. ____Foot deformity (bunion, hammer toes, Charcot, etc.)
   f. ____Poor circulation in feet (symptoms, signs, tests, or a diagnosis of arterial insufficiency must be documented)

Please note that any condition checked must be documented in the medical records submitted. If the medical records do not include proper documentation of the checked condition, medical records and TRX will have to be rewritten and resubmitted to be compliant for Medicare

3. I am treating this patient under comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Signature, name, date, and NPI (Must be an M.D. or D.O.):

Signature: _____ Name(Printed):_____

Address: _____ City: _____ State: _____ Zip:_____

Date: _____ NPI:_____

(Please note this form expires within 3 months of the signature date)