Statement of Certifying Physician for Therapeutic Footwear

Patient Name: ____

Address: ____

Phone: ____

I certify that all of the following are true:

1. This patient has diabetes mellitus ICD-10 Code:
   DIAGNOSIS:

❏ NIDDM PVD	E11.51	❏ IDDM PVD	E10.51
❏ NIDDM PN	E11.42	❏ IDDM PN	E10.42
❏ NIDDM w/Ulcer	E11.621	❏ IDDM w/Ulcer	E10.621

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

❏ History of partial or complete amputation of the foot

❏ History of pre-ulcerative callus

❏ History of previous foot ulceration

❏ Peripheral neuropathy with evidence of **callus formation**

❏ Poor circulation

❏ **FOOT DEFORMITIES:**

❏ Extosis	Rt M77.51	Lt M77.52
❏ Bunion	Rt M20.11	Lt M20.12
❏ Hammertoe	Rt M20.41	Lt M20.42
❏ Callus	L84	
❏ Other Def Toes	Rt M20.5X1	Lt M20.5X2
❏ Amputation Hallux	Rt Z89.411	Lt Z89.412
Lesser Toes	Rt Z89.421	Lt Z89.422
Foot	Rt Z89.431	Lt Z89.432

❏ Other ____

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

4. This patient requires extra depth shoes and accommodative inserts

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Certifying Physician Information

Doctor Name: ____

Address: ____

Phone: ____

Signature: ____

Date: ____

NPI #____

**This form should be filled out by the physician managing the patient's diabetes, and faxed to The Sole Authority or the patient can bring it to their appointment.*

THE SOLE AUTHORITY

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