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

_____

_____

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

954-597-7060 PHONE • 954-721-3772 FAX

8307 N. Pine Island Road • Tamarac, FL 33321 info@thesoleauthority.com

WWW.THESOLEAUTHORITY.COM