



**STATEMENT OF CERTIFYING PHYSICIAN  
For Diabetic Shoes and Inserts**

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medicare Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 Code \_\_\_\_\_

I certify that all of the following statements are true:

1. This patient has diagnosis of Diabetes Mellitus.
2. This patient also has one or more of the following conditions (circle 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
  - f. Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her condition.
4. This patient needs special shoes (depth or custom molded) because of his/her condition.

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date \_\_\_\_\_ UPIN Number \_\_\_\_\_

Physician Signature \_\_\_\_\_

***Your physician can complete and fax to:***

*Erie: (814) 877-5260 Bradford: (814) 362-9113 Meadville: (814) 337-6902  
Jamestown: (716) 664-6570 Fredonia: (716) 672-4706*