O N E   S O U R C E   M E D I C A L   S O L U T I O N S ,   I N C .

One Company. Multiple Solutions.™

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES
NPI NO. 1144311531

Patient:____ **Date**:_____________

Address:_____________________________________ **City**:______________ **State**:____ **Zip**:______

DOB:__________ **HICN**:_________________________ **Medicaid No**.:________________________

I certify that all of the following statements are true:

1. **This patient has diabetes mellitus - ICD-9 Code:____________**
   (ICD-9 diagnosis codes 250.00 - 250.91)
2. **This patient has one or more of the following conditions. (Circle all that apply):**
   - a) **History of partial or complete amputation of the 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 diabetes.**
4. **This patient needs special shoes (depth or custom-molded shoes) and/or orthotic inserts (custom or heat-molded) because of his/her diabetes.**

PRESCRIPTION

Evaluate and perform comprehensive pedorthic assessment. Dispense:

( ) **Extra Depth Therapeutic Footwear**
( ) **Three (3) Pairs of Custom or Heat-Molded Accommodative Orthotic Inserts**

Offload high pressure areas as needed and provide total contact fit to the patient.

Physician Signature: ____

Date Signed: ____

Physician Name (print): ____

Physician Address: ____

Physician NPI: _______________________ **Physician UPIN:** ________________

11520 N. CENTRAL EXPRESSWAY, SUITE 233
DALLAS, TEXAS 75243
PHONE (214) 421-7000 FAX (214) 421-7001