Fax to 270-747-8779

Statement of Certifying Physician (SCP)

THERAPEUTIC FOOTWEAR FOR PERSONS WITH DIABETES & COMPLICATIONS

The purpose of this document is to qualify the patient for insurance coverage of therapeutic footwear, the absence of which, may predispose the patient to diabetic ulcers of the feet.

Patient Name ____ **DOB** ___________________________

Patient Telephone ____ **Date of last visit**_________________

Diagnosis (ICD-10) ____ **Type I** ___ **Type II** ___ **Other** __________

By signing below, I certify that:

This patient has diabetes mellitus.
I am treating this patient under a comprehensive plan of care for his/her diabetes.
This patient needs customized footwear due to the following complications:

☐ Previous amputation of the other foot, or part of either foot	☐ Foot deformity of either foot
☐ History of previous foot ulceration of either foot	☐ Poor circulation of either foot
☐ History of pre-ulceration calluses of either foot	☐ Peripheral neuropathy with evidence of callus formation

Physician Signature (**MD OR DO ONLY**) ____ Date _______________________

Physician Name ____NPI _________________________

Phone ____Fax ____________________________________ Rev 02/22/20

By Appointment