Pro-Fit, Inc
1529 3rd Ave S
Birmingham, AL 35233
205.326.0050 Fax: 205.324.2226

Statement of Certifying Physician for Therapeutic Shoes

Patient: _____ DOB _____

MCR or MCD Number #: _____

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 & have medical records attached fully describing the medical necessity for the request of diabetic shoes.

a. History of partial or complete amputation.
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.

DOCUMENTATION OF THE ABOVE INDICATED CONDITION IS REQUIRED. PLEASE SEND MEDICAL RECORDS.

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) and/or inserts because of his/her diabetes.

Physicians Signature: _____ Date _____

Physician Name (Printed): _____NPI: _____

MCD Provider Number: _____ Phone: _____

In order to meet Medicare & Medicaid criterion 2, the certifying physician must either:

i. Personally document one or more of criteria a – f in the medical record prior to signing the certification statement; **or**

ii. Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that documents one of more of criteria a – f.