SSMHealth at Home

Prescription for Therapeutic Shoes & Inserts
Statement of Certifying Physician

Date: _____

Patient Name: _____ DOB: _____

Patient Address: _____

MBI (Medicare Number):_____

Item: One pair of therapeutic extra depth shoes to accommodate multi-density inserts
Choose one: ☐ Yes _____ ☐ No _____

Item: Number of pairs of shoe inserts: 3 (up to three per year)
Choose one: ☐ Heat Moldable Insert ☐ Custom-Fabricated Insert

Statement of Certifying Physician for Therapeutic Shoes & Inserts

I certify that all the following statements are true:

1. This patient has diabetes mellitus Dx Code_____
2. This patient has one or more of the following conditions (must be addressed in clinical documentation):
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ Poor circulation
3. I am treating the patient under a comprehensive plan of care for their diabetes.
   ☐ Yes ☐ No
4. This patient needs one pair of special shoes (extra depth shoes) because of their diabetes.
   ☐ Yes ☐ No

Physician Name (Printed - Must be an M.D. or D.O.): _____

Physician Signature: _____ Date signed: _____

Physician Address: _____

Physician NPI#: _____