

**CERTIFICATE OF MEDICAL NECESSITY  
For Therapeutic Footwear  
STATEMENT OF CERTIFYING PHYSICIAN (M.D. or D.O.)**

Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_

I certify that all of the following statements are true:

- 1) I am treating this patient under a comprehensive plan of care for diabetes and the patient needs diabetic shoes; and
- 2) This patient has diabetes mellitus which I have notated/documentated in patient's medical records.  
ICD-9 Code(s): \_\_\_\_\_ (250.00-250.91); and
- 3) This patient has one or more of the following conditions **(as documented in patient's medical records).**  
**Check all that apply:**

- a. Previous amputation of the other foot, or part of either foot, or ICD-9 Code(s): \_\_\_\_\_
  - b. History of previous foot ulceration of either foot, or ICD-9 Code(s): \_\_\_\_\_
  - c. History of pre-ulcerative callus of either foot, or ICD-9 Code(s): \_\_\_\_\_
  - d. Peripheral neuropathy and evidence of callus formation of either foot, or ICD-9 Code(s): \_\_\_\_\_
  - e. Foot deformity of either foot (bunion, hammertoes, \_\_\_\_\_) or ICD-9 Code(s): \_\_\_\_\_
  - f. Poor circulation in either foot ICD-9 Code(s): \_\_\_\_\_
- (i.e. symptoms, signs, or a diagnosis of small or large vessel arterial insufficiency in the legs)

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

Date: \_\_\_\_\_

**Signature and date stamps are not acceptable**

Physician Name (Print) \_\_\_\_\_

NPI #: \_\_\_\_\_

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

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

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This is a request for the M.D. or D.O. who has the primary responsibility of treating the patient's systemic diabetes, to complete the Certificate of Medical Necessity above for the patient listed so that we (the DMEPOS Supplier) may provide them with therapeutic shoes and inserts. In order to qualify for Medicare reimbursement, your certification that they meet the conditions listed above is required. Per Medicare guidelines (excerpt below from Cigna Government Services) in the event of an audit for this particular patient's claim for therapeutic shoes and inserts:

***"It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed above is present. If requested by the supplier, you must provide copies of those records."*** If you would not be able to meet such a request, please contact us prior to completing this form. We greatly appreciate your assistance in providing for this patient.

**PLEASE INCLUDE MEDICAL NOTES RELEVANT TO SECTION 3 a-f ABOVE  
AND RETURN WITH THIS FORM**