



**STATEMENT OF CERTIFYING PHYSICIAN  
For Diabetes Shoes and Inserts**

(Up to 3 pairs of multi-density inserts)

(Complete patient information **OR** attach patient face sheet when faxing.)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

Medicare Number \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 Code \_\_\_\_\_

**I certify that ALL of the following statements are true:**

1. This patient has diagnosis of Diabetes Mellitus.
2. This patient also has one or more of the following conditions  
(**Must circle at least one.**)
  - a. History of partial or complete amputation of 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 condition.
4. This patient needs therapeutic shoes because of his/her condition.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ UPIN # \_\_\_\_\_

***Your physician can complete and fax to:***

Erie:	Phone (814) 877-6529	Fax (814) 455-9440
Bradford:	Phone (814) 362-8141	Fax (814) 362-9113
Meadville:	Phone (814) 337-6900	Fax (814) 337-6900
Jamestown:	Phone (716) 664-5092	Fax (716) 664-6570
Fredonia:	Phone (716) 672-4704	Fax (716) 672-4706