

Certificate of Medical Necessity

The following patient qualifies for diabetic shoes under the Medicare Diabetic Shoe Bill. Medicare requires that patients qualified for the shoes obtain a signed certificate of medical necessity from the physician that treats the patient's diabetes. The Medicare Diabetic Shoe Bill was passed in 1993 in an attempt to decrease the number of diabetic amputations through preventative shoe gear.

Patient's name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SS#: _____ Medicare#: _____

Secondary Insurance: _____

Shoe type: Lace Velcro Men's Women's Size(length/width): _____ Left _____ Right

I certify that all the following statements are true:

1. This Patient has diabetes mellitus: (Please check one)
 Insulin dependent Non Insulin Dependent
 Controlled Uncontrolled
2. This Patient has one or more of the following conditions:
 - History of partial or complete amputation of the foot.
 - History of previous foot ulceration
 - Peripheral neuropathy with evidence of callus formation
 - History of pre-ulcerative callus
 - Foot Deformity
 - Poor circulation
3. I am treating the patient under a comprehensive plant of care for his/her diabetes.
4. Please state from the patient's medical record (or attach a copy), indicating the nature of the foot disorder that warrants the need for shoes. _____

Please check all that apply to this patient:

- | | |
|--|--|
| <input type="checkbox"/> Neuroma of amputation stump, 997.61 | <input type="checkbox"/> Traumatic amputation of toe without complication, 895.0 |
| <input type="checkbox"/> Traumatic amputation of toe(s) with complication, 895.1 | <input type="checkbox"/> Corns and Calluses, 700.0 |
| <input type="checkbox"/> Bone Spur, 726.91 | <input type="checkbox"/> History of amputation of great toe, V49.71 |
| <input type="checkbox"/> Open wound of toe(s) without complication, 893.0 | <input type="checkbox"/> Open wound of toe(s) with complication, 893.1 |
| <input type="checkbox"/> History of amputation of other toe(s), V49.72 | <input type="checkbox"/> Great toe angles toward other toes, 735.0 |
| <input type="checkbox"/> Other acquired deformities of the toe, 735.8 | <input type="checkbox"/> Great toes angles away from other toes, 735.1 |
| <input type="checkbox"/> Diabetes with peripheral circulatory disorders, 250.7 | <input type="checkbox"/> Gangrene, 785.4 |

Physician's Name: _____ Phone: _____ UPIN: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

I hereby authorized payment of medical benefits to Family Foot Care Center for services furnished. I further authorize the release of any medical information required to process insurance claims on my behalf. I hereby permit a copy of this authorization to be valid as the original. I understand that all costs of devices and supplies not paid for by my insurance company will become my responsibility. The footwear has been properly fitted with heat molded inserts and deliver to meet my needs and I have been given the Medicare Supplier Standards form.

Patient's Signature: _____ Date: _____

Unable to sign-Why? _____ Caregiver-Authorized Signature: _____