Fax to Pedorthic Technologies Inc.

Fax (401) 732-8264 Phone (401) 732-7623

Statement of Certifying Physician for Therapeutic Footwear

Must be completed by doctor

Patient name _____ Date of birth ___/___/___

Primary Diagnosis

Not requiring secondary DX		**Requiring secondary DX**
With neuropathy	With poor circulation	
☐ 250.60	☐ 250.70	☐ 250.00
☐ 250.61	☐ 250.71	☐ 250.01
☐ 250.62	☐ 250.72	

Secondary Diagnosis

Please check all that apply

ICD-9	**Description**	**ICD-9**	**Description**
☐ 337.1	Peripheral neuropathy	☐ 459.81	Venus insufficiency / poor circulation
☐ 700	History of pre-ulcerative callus	☐ 736.70	Foot deformity
☐ V49.___	History of partial or complete amputation: 71 – Great toe 72 – Other toe 73 – Foot 74 – Ankle 75 – Below knee	☐ 707.___	History of ulceration: 1 – Ulcer, lower limb unspecified 8 – Ulcer, chronic, other specified site

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By my signature below, I state that I am treating this patient under a comprehensive plan of care for his/her diabetes, and that I have evaluated this patient's medical condition and determined that this patient needs therapeutic shoes (depth inlay shoes) and inserts because of his/her diabetes and the indicated secondary diagnosis. I certify that the information provided is true and correct and supported by the patient's medical records.

Certifying physician signature _____ NPI #_____ Date ___/___/___

Certifying physician's name, address and telephone number (please stamp/print):

_____

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