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Routine Foot Care Letter

Patient Name _____

Medicare # _____ DOB _____

Name of Treating Physician _____

Date of Last Exam _____

This Patient has Systemic Conditions:

___ NIDDM / IDDM
___ PVD
___ Neuropathy

This Patient is a high risk for complications and infections, therefore qualifies for Medicare routine foot care.

Certifying Physician Information

Completed by Physicians who is managing a patient's conditions

Physician Name _____

Signature _____ Date _____

Address _____

_____

NPI # _____