Next Step Prosthetics

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Statement of Certifying Physician

Patient Information		
Patient Name (Last, First, MI)	Patient ID	Patient DOB
Device Type **Bilateral Diabetic Shoes & Inserts**	Diagnosis Code(s)	Visit Date
HIC Number		

The physician listed below certifies that all of the following statements are true:
(Physician must be an MD or DO)

1. **This patient has diabetes mellitus.**
2. **This patient has the following conditions (please check all that apply):**
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ Poor circulation
3. **I am treating this patient under a comprehensive plan of care for his/her diabetes.**
4. **This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.**
5. **I have seen this patient for diabetes management within the last 6 months. I understand that the shoes must be delivered within 3 months of the signature date on this form AND within 6 months of the last in-person physician visit.**

Physician Name	Physician NPI
Physician Address	
Physician Work Phone	Physician Fax

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

Print **Date**

**** MUST BE SIGNED BY MD OR DO ****