Northeast Medical Products, Inc.

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STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES & ORDER FORM

Patient Name: _____ Phone: _____

Address _____

DOB _____ HIC#_____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD10 code_____
2. This patient has one or more of the following conditions
   (**Circle all that apply and provide the correct ICD10 code**)
   a. History of partial or complete amputation of the foot ICD10 code_____
   b. History of previous foot ulceration ICD10 code_____
   c. History of pre-ulcerative callus ICD10 code_____
   d. Peripheral neuropathy with evidence of callus formation ICD10 code_____
   e. Foot deformity ICD10 code _____
   f. Poor circulation ICD10 code _____
   g. Length of need _____

3. I am treating this patient under a comprehensive plan of care for his/her diabetes. They had an in-person visit with me on _____, at which time diabetes management was addressed in addition to the patient's need for diabetic shoes.

4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

EQUIPMENT:
_____ Diabetic Shoes
_____ Non-Custom Heat Moldable Inserts (3 Pair)

Physician Name (printed): _____

Physician Signature _____Date Signed _____

Address_____

Phone _____ Fax _____

NPI _____