Certificate of Medical Necessity for Diabetic Footwear

Patient Information

- Name: _____
- Date of Birth: _____
- Address: _____
- Insurance ID #: _____

Provider Information

- Physician Name: _____
- NPI #: _____
- Address: _____
- Phone: _____
- Fax: _____

Medical Justification

I certify that the above-named patient has **diabetes mellitus** and has one or more of the following conditions (check all that apply):

☐ History of partial or complete amputation of the foot
☐ History of previous foot ulceration
☐ History of pre-ulcerative calluses
☐ Peripheral neuropathy with evidence of callus formation
☐ Poor circulation (peripheral vascular disease)
☐ Foot deformity (e.g., bunion, Charcot foot, hammertoes)

Statement of Necessity

Due to the presence of diabetes mellitus and the above risk factors, the patient requires **therapeutic shoes and/or inserts** to:

- Prevent ulceration and complications
- Protect against injury due to neuropathy and/or deformity
- Improve mobility and maintain independence

I am treating this patient under a comprehensive plan of care for their diabetes and related foot conditions.

Prescription

☐ One pair of depth shoes (custom-fitted)
☐ One pair of custom-molded shoes
☐ Up to three pairs of heat-molded or custom-fabricated inserts per year
☐ Modifications (please specify): _____

Physician Certification

I certify that this patient has diabetes mellitus, is being treated under a comprehensive plan of care, and requires therapeutic footwear as outlined above.

Physician Signature: _____
Date: _____