Community Pharmacy
4400 Teasley Lane Ste 100 / Denton, TX 76210 / Phone 940-382-1618 / Fax 940-898-1986
Tax ID 75-2955796 / NPI 1679515977

Statement of Certifying Physicians For Therapeutic Footwear

Date:_____ Patient Name: _____Date of Birth:_____

Address: _____City: _____State: _____Zip:_____

Phone Number:_____Medicare Number:_____

DIABETIC/THERAPEUTIC SHOES-CERTIFICATE OF MEDICAL NECESSITY (CMN)

☐ A5500 Depth Shoe non-custom ☐ A5512 Heat Molded Off-the-Shelf Inserts

☐ Other_____

Medicare and insurance requires you to complete the following certification. You must also either have examined the patient within the last six months or agree to the examination of another healthcare professional of an in-person visit within the last six months. Community Pharmacy must obtain medical records/notes supporting the associated conditions you specify below. Please submit the supporting documentation along with this Certifying Statement.

I certify that all of the following statements are true:

1. **This patient has diabetes mellitus: (Please circle)**
   Insulin Dependent Non-Insulin Dependent
   Controlled Uncontrolled
   ICD-9 Code:_____
2. **This patient has one or more of the following conditions: (Check all that apply)**
   - ☐ History of partial or complete amputation of foot, or of both feet
   - ☐ History of previous foot ulceration of either foot
   - ☐ History of pre-ulcerative callus of either foot
   - ☐ Peripheral neuropathy with evidence of callus formation.
   - ☐ Foot deformity of either foot
   - ☐ Poor circulation (*testing in notes must accompany this diagnosis)
3. I am treating this patient under a comprehensive plan of care for his/her diabetes
   This patient was last seen and treated for Primary Diagnosis on:_____
4. This patient needs special shoes because of his/her diabetes.

Please check the diagnoses that apply.

	Neuropathy, Diabetic 250.6		Diabetes with peripheral circulatory disorders 250.7		Traumatic amputation of toe(s) with complications 895.1
	Ulcer, Diabetic 250.8		Hallux Malleus or Hallus Rigidus 735.2		History of amputation of great toe V49.71
	Open wound of toe(s) without complications 893.0		Open wound of toe(s) with complications 893.1		History of amputation of other toe(s) V49.72

Acquired deformities of the foot.

	Great toe angles toward other toes 735.0 Hallux Valgus-Bunion		Great toe angles away from other toes 735.1 Hallux Varus-Bunionette		Other acquired deformities of the toe. 735.4 Hammertoe
	Claw Or Mallet Toe 735.4				
	Corns and Callousites 700				
	Other Diagnosis:				

BY SIGNING YOU ARE STATING THAT THE PATIENT IS UNDER YOUR DIRECT CARE, AND AS THE PRIMARY OR TREATING PHYSICIAN THIS ORDER OF PRODUCTS IS DEEMED MEDICALLY NECESSARY.

Physician Name:_____ NPI: _____

Address: _____

City: _____State:_____ Zip: _____

Phone:_____ Fax:_____

Physician (MD or DO only) Signature_____Date:_____

Physician Printed Name_____

(*The use of signature or date stamps is not acceptable)*