Claiborne Prosthetics & Orthotics
Statement of Certifying Physician for Therapeutic Shoes

Patient name:_____

HIC #:_____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus.

2) This patient has one or more of the following conditions**: (Circle all that apply):**

   a) History of partial or complete amputation of the foot

   b) History of previous foot ulceration

   c) History of pre-ulcerative callus

   d) Peripheral neuropathy with evidence of callus formation

   e) Foot deformity

   f) 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.

Physician signature:_____

Date Signed:_____

Physician name (printed - **MUST BE AN M.D. OR D.O.):**

_____

Physician address: _____

_____

Telephone # _____ Physician NPI: _____

CMS CENTERS for MEDICARE & MEDICAID SERVICES	**PLEASE return this completed from plus a copy of your office visit notes from your medical records indicating that you are managing the patient's diabetes. This note should be within 6 months prior to delivery of the shoes and inserts.**
Mail to:	Claiborne Prosthetics 1041 Hawthorne Lane – Ste B Charlotte, NC 28205
Or Fax to;	704-333-4707
Any questions	Call Jackie at 704-333-4700