# STATEMENT OF CERTIFYING PHYSICIAN

*Must be signed by an MD or DO
*Must provide office notes for treating Diabetes and foot exam that support the information below

Patient Information:
Name: ___________________________________
Address: __________________________________
City/St/Zip: _______________________________
Phone: ___________________________________
Dob: _______________________

Provider Information:
Kesling Home Health Care LLC
1115 W. Market St., P.O. Box 328
Logansport, IN 46947
Phone: 574-735-0082 /Fax:574-753-3910
NPI: 1568642056 / TAX ID: 351994022

I hereby certify that the patient mentioned above:

1. Has Diabetes
   □ Type I - ICD-10 Code(s): _________ □ Type II - ICD-10 Code(s): _________

2. This patient has the following conditions (check all that apply):
   □ a. History of partial or complete amputation of foot
      □ Left □ Right Specify:________________________________________
   □ b. History of previous foot ulceration
      □ Left □ Right Specify:________________________________________
   □ c. History of pre-ulcerative callus
      □ Left □ Right Specify:________________________________________
   □ d. Peripheral neuropathy with evidence of callus formation
      Specify:________________________________________________
   □ e. Foot Deformity (bunion, hammer toe, etc)
      □ Left □ Right Specify:________________________________________
   □ f. Poor Circulation
      □ Left □ Right Specify:________________________________________

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 Attestation: I have examined this patient myself OR have obtained, reviewed, initialed, dated, and indicated agreement with the diagnosis and documentation from the medical records of the provider performing the exam and/or prescribing the diabetic shoes/inserts.**

Physician's Signature:__________________________________ Date:__________________

Printed Name:________________________________________ NPI:___________________
Address: ____________________________________________________________________
City: ____________________________ State: ___________ Zip: ___________________
Phone #: (_____)-______-_____________ Fax #: (_____)-______-__________