STATEMENT OF CERTIFYING PHYSICIAN

Patient Info

PATIENT NAME	DATE OF BIRTH
PATIENT MBI#	RECORD ID

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 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
PHYSICIAN NAME	NPI#

PHYSICIAN ADDRESS

CITY	STATE	ZIP CODE