PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY FOR THERAPEUTIC DIABETIC SHOES AND INSERTS
MUST BE COMPLETED BY AN M.D. OR D.O.

Patient: _____

Provider Number: _____

I certify that all of the following statements are true:

Required: This patient has diabetes mellitus ICD-10-CM code: _____.
(ICD-10-CM codes E10.10 – E13.9)

(Circle all that apply)

- Foot ulcers
- Previous amputation of the contralateral foot, or part of either foot, due to a micro-vascular disease secondary to diabetes
- History of previous ulceration of either foot
- Peripheral neuropathy with evidence of callous formation of either foot
- Deformity of either foot, that is, rocker bottom foot or Charcot foot
- Documentation of compromised vascular disease in either foot
- Positive monofilament examination indicating diabetic neuropathy

At least one of following are required for **custom orthotics (HCPCS code A5513) and/or shoes (code A5501**). Circle all that apply:

- Diabetes mellitus with neurological manifestations
- Diabetes mellitus with peripheral circulatory disorders
- Diabetes mellitus with other specified disorders (amputations, significant deformities and/or pre-ulcerations)

I am treating this patient under a comprehensive plan of care for his/her diabetes.

This patient needs special shoes (off-the-shelf or custom-molded) and/or inserts because of his/her diabetes.

Items prescribed: _____

Physician name (printed): _____
(MUST BE AN M.D. OR D.O.)
Address: _____

Telephone Number: _____

Provider ID Number: _____

California Medical License Number: _____

Physician Signature (original): _____ Date: _____
(MUST BE AN M.D. OR D.O.)