STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

NOTE: For coverage by Medicaid under the THERAPEUTIC SHOES–

THIS DOCUMENT MUST BE SIGNED BY THE MD, DPM OR DO WHO IS MANAGING THE PATIENT'S CONDITION AND THE STATEMENTS DOCUMENTED BELOW MUST BE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD

Patient Name: _____

I certify that all of the following statements are true:

1) This patient has **one or more** of the following conditions (**check all that apply**)

History of partial or complete Amputation of the foot, please see examples	☐ Lower limp amputation, foot (icd10 - Z89.439)(icd9 - V49.73) ☐ Lower limp amputation, great toe (icd10 – Z89.419)(icd9 - V49.71) ☐ Lower limp amputation, lesser toe(s) (icd10 Z89.429) (icd9 - V49.72)
History of previous foot ulceration.	☐ Ulcer of heel and midfoot(icd10 – L97.409) (icd9 -707.14) ☐ Ulcer other part of foot (icd10 – L97.509) (icd9 - 707.15)
History of pre-ulcerative foot callus	☐ History of pre-ulcerative callus (icd10 –L98.499) (icd9 - 707.9)
Peripheral neuropathy and Evidence of callus formation.	☐ Polyneuropathy in diabetes (icd 10 - E08.42) (icd9 - 357.2) and History pre-ulcerative callus (icd 10 - L98.499) **BOTH MUST BE PRESENT**
Foot Deformity: Other ICD-10: _____	☐ Claw toe (icd10 – M20.10) (icd9 - 735.5) ☐ Hammer toe (icd10 – M20.40) (icd9 - 735.4) ☐ Hallux Valgus (icd 10 - M20.10) (icd9 - 735.0) ☐ Hallux Rigidus (icd 10 - M20.20) (icd9 - 735.2) ☐ Unspecified acquired deformity of toe (icd 10 -M20.60) (icd9 - 735.9) ☐ Unspecified deformity of ankle and foot, acquired (M21.969) (736.70) ☐ Charcot Arthropathy(icd 10 – M14.60) (icd9 - 713.5)
Poor circulation in either foot. Other ICD-10: _____	☐ Atherosclerosis of the extremities, unspecified (icd10- I70.209) (440.20) ☐ Atherosclerosis of the extremities with intermittent claudication (icd10 I70.219) (icd9 - 440.21) ☐ Atherosclerosis of the extremities with ulceration (icd10-I70.25)(440.23) ☐ Peripheral vascular disease, unspecified (icd10-I73.9) (icd9 - 443.9)

2) I am treating this patient under a comprehensive plan of care for his/her foot condition(s).
3) This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her foot condition(s).
4) With orthopedic footwear, the patient's prognosis is: _____
5) **The above information is documented in the patient's medical record, and a copy of this form has been entered into the patient's medical record.**

Certifying Physician Name: _____

NPI #: _____ **Address:** _____

Telephone: _____ **Date:** _____

Physician Signature: _____ **Physician Stamp:** _____

Michael's Pharmacy

PLEASE FAX COMPLETED FORM TO 718-921-9777