TRIPLE-S ADVANTAGE

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____ HIC Number: _____

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 (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 Name:_____ NPI #: _____

Physician Signature :_____ Date Signed:_____

Address: _____ Phone #:( ) _____ - _____

_____ State _____ Zip-Code _____ Fax #:( ) _____ - _____