

**CERTIFICATE OF MEDICAL NECESSITY**  
**Diabetic Shoes and Inserts**

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For diabetic shoes and inserts to be covered by Medicare, the patient's medical record must contain sufficient information about the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement.

*Instructions: Please complete as accurately as possible, and sign below to confirm patient's need for diabetic shoes and inserts.*

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Medicare/HIC#** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

I certify that the following statements are true:

1. This patient has diabetes mellitus. ICD-10 code: E \_\_\_\_\_
2. This patient has one or more of the following conditions: (please check all that apply)  
**B**     **A.**  Peripheral Neuropathy with evidence of callus formation E11.40; **and/or**  
          **B.**  Poor Circulation E11.51; **and/or**  
          **C.**  History of pre-ulceration callus L97.509; **and/or**  
          **D.**  Foot Deformity M21.969; **and/or**  
          **E.**  History of partial or complete amputation of the foot; **and/or**  
          **F.**  Other: \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_
3. I am treating this patient under a comprehensive plan of care for his/her diabetes and recently saw said patient in-office on \_\_\_\_\_ (Date of Service). Their stated diagnoses have been personally documented by me in their file.
4. This patient needs special shoes (depth or custom molded shoes) and insert(s) because of his/her diabetes.

**Physician Signature (MD or DO):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Name (printed):** \_\_\_\_\_ **NPI#:** \_\_\_\_\_

**Phone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

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**PHYSICIAN'S PRESCRIPTION**  
**Diabetic Shoes and Inserts**

Please provide the above named patient with the following:

- One pair of therapeutic non-custom depth-inlay shoes (A5500) with three pair of non-custom heat moldable multi-density inserts (A5512) or with three pairs custom molded multi-density inserts (A5513)
- One pair of custom made shoes (A5501)

Recommended modifications to the above options

- A**  Toe Filler (L5000)
- B**  Shoe Modification (A5507)

Doctor's comments:

\_\_\_\_\_

By signing below, all of the information contained in this statement is true and accurate to the best of my knowledge.

**Physician Signature (MD or DO):** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Name (Printed):** \_\_\_\_\_ **NPI#** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

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**Note to Physician:** The Comprehensive Error Rate (CERT) Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), performs medical review for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided to Medicare Beneficiaries to determine paid claims error rates for Medicare contractors and providers. It is your responsibility as the ordering physician to determine and document the medical need for all healthcare services. The CERT contractor may request that the supplier obtain this information from you in order to verify that Medicare coverage criteria have been met.

**Please fax this form to: 913-451-4482**  
**Comfort Plus Shoes & Footcare – 11715 Roe Ave, Leawood, KS 66211 – 913-451-4494**