COMFORT PLUS SHOES AND FOOTCARE

11715 Roe Ave
Leawood,KS 66211

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contactus@comfortplusshoes.com

Physicians Certification Statement for Therapeutic Footwear

Certifying Physician Information

Print Name _____ NPI # _____

Street Address _____

City/State _____ Zip Code _____ Tel #. _____

Signature _____ Date _____

I Certify that all of the following apply:

I am Treating this Patient under a Comprehensive plan of care for their Diabetes

ICD-9 CODE _____

This Patient needs Therapeutic Footwear and /or Inserts because of their Diabetic Condition.

This patient has one or more of the following conditions: (Check all that apply)

This Patient has Diabetes Mellitus_____

Poor Circulation _____ Foot Deformity _____ History of Pre-ulcerative Callous _____

Therapeutic Footwear Prescription

Patient's Name (Printed) _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Tel No. _____

Dx _____ Medicare # _____ Secondary _____

Footwear

Extra Depth _____
Custom Made _____

Supports

Conformable Inserts _____
Custom Made _____

Prescribing Physician Information

Print Name _____ NPI# _____

Address _____

City/State _____ Zip Code _____ Tel# _____

Signature _____ Date _____