State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

Statement of Certifying Physician for Diabetic Shoes

Name: _____

MID: _____

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 Signature: _____

Date Signed: _____ NPI: _____

Physician name (printed – **MUST BE AN M.D. OR D.O.**)

_____

Physician address:

_____

Physician telephone #: _____