



STATE OF RHODE ISLAND  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
MEDICAID PROGRAM

## Certificate of Medical Necessity 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. **(Circle 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.

Prescriber Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_ NPI: \_\_\_\_\_

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

\_\_\_\_\_

Prescriber address: \_\_\_\_\_

Prescriber telephone #: \_\_\_\_\_

**Proof of medical necessity is valid for 12 months from the date of issue.**