**Medical Management & Policy**
**Fax Number: 412-544-2921**

# Certificate of Medical Necessity (CMN) for Therapeutic Shoes in Diabetics

**Date:** ____/_____/_______ **Requesting Provider:** ________________________________

**Pt. Name:** __________________________________ **I.D. Number:** _____________________

| | | Y | N | D |
|---|---|---|---|---|
| 1. | Does the patient have diabetes mellitus and one or more of the following conditions? (Circle all that apply)<br>a. History of partial or complete amputation of the foot<br>b. History of previous foot ulceration<br>c. History of pre-ulcerative callus<br>d. Peripheral neuropathy with evidence of callus formation<br>e. Foot deformity<br>f. Poor circulation<br>g. Hemiplegia/Hemiparesis<br>h. Foot drop | Y | N | D |
| 2. | This patient is under a comprehensive plan of care by the certifying MD or DO for his/her diabetes. | Y | N | D |
| 3. | The patient needs special shoes (extra depth or custom-molded shoes) because of his/her diabetes. | Y | N | D |
| 4. | Is the certifying physician (managing the patient's diabetes and specifying condition indicated in 1) an MD or DO? | Y | N | |
| 5. | Who is prescribing the therapeutic shoes?<br>Name: __________________________________________ Credentials: __________________________ | | | |

**Additional Clinical Rationale (Please Print):**

**Contact Name:** __________________________________ **Phone :**_________________

_________________________________________ ______________________________

**Physician Signature (Stamps are not acceptable)** **Date**

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

**Requested Information:**
1. Typed office note with pertinent information.