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: _____**

1. Does the patient have diabetes mellitus and 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 g. Hemiplegia/Hemiparesis 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?

   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.