

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

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

Pt. Name: _____ **I.D. Number:** _____

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|---|---|---|---|
| <p>1. Does the patient have diabetes mellitus and one or more of the following conditions? (Circle all that apply)</p> <ul style="list-style-type: none"> 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
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3. The patient needs special shoes (extra depth or custom-molded shoes) because of his/her diabetes.	Y	N	D
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4. Is the certifying physician (managing the patient's diabetes and specifying condition indicated in 1) an MD or DO?	Y	N	
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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.