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| **Certificate of Medical Necessity (CMN) for Therapeutic Shoes for Diabetics** |
| Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Requesting Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pt. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_ I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Does the beneficiary have diabetes mellitus? Y N
2. Has the Certifying Physician documented in the beneficiary’s medical records one or more of the following conditions? (Please circle all that apply)
3. Previous amputation of the other foot, or part of either foot
4. History of previous foot ulceration of either foot
5. History of pre-ulcerative calluses of either foot
6. Peripheral neuropathy with evidence of callus formation of either foot
7. Foot deformity of either foot
8. Poor Circulation in either foot
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| 1. This patient is under a comprehensive plan of care by the certifying MD or DO

For his/her diabetes. Y N |
| 1. The patient needs therapeutic shoes because of his/her diabetes. Y N
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| 1. Is the certifying physician (managing the patient’s diabetes) an MD or DO? Y N
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| 1. 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) = yes, (N) = No |