KINETIC O&P LTD.

STATEMENT OF CERTIFYING PHYSICIAN

Patient Name:_____ DOB: _____ HIC#_____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD-10 diagnosis code _____
2. This patient has one or more of the following conditions. (Circle all that apply):

a) Peripheral neuropathy
b) History of previous foot ulceration
c) History of pre-ulcerative callus
d) History of partial or complete amputation of the foot
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.
5. I have seen this patient for diabetes management within the last 6 months. I understand that the shoes must be delivered within 3 months of the signature date on this form AND within 6 months of the last in-person physician visit.

Physician signature: _____

Date Signed:_____

Physician name (printed - **MUST BE AN M.D. OR D.O.**)_____

Physician address:_____

Physician NPI: _____

452 S. Main Street, Bourbonnais, IL 60914
PH: 815-401-7260 FAX:815-401-7267
info@kineticop.com