Arise Prosthetics LLC

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Statement of Certifying Physician

Patient Information		
Patient Name (Last, First, MI)	Patient ID	Patient DOB
Device Type	Diagnosis Code(s)	Visit Date
HIC Number		

The physician listed below certifies that all of the following statements are true:
(Physician must be an MD or DO)

1. **This patient has diabetes mellitus.**
2. **This patient has the following conditions (please check all that apply):**
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ 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 Name	Physician NPI
Physician Address	

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

Signature _____ **Date** _____

Print Name _____