



Arise Prosthetics LLC

4527 N. 16th Street, Suite 104 Tel: (602) 864-5560
Phoenix, AZ 85016-5353 Fax: (602) 864-4958

Statement of Certifying Physician

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

The physician listed below certifies that all of the following statements are true: <i>(Physician must be an MD or DO)</i>	
<p>1. This patient has diabetes mellitus.</p> <p>2. This patient has the following conditions (please check all that apply):</p> <p><input type="checkbox"/> History of partial or complete amputation of the foot</p> <p><input type="checkbox"/> History of previous foot ulceration</p> <p><input type="checkbox"/> History of pre-ulcerative callus</p> <p><input type="checkbox"/> Peripheral neuropathy with evidence of callus formation</p> <p><input type="checkbox"/> Foot deformity</p> <p><input type="checkbox"/> Poor circulation</p> <p>3. I am treating this patient under a comprehensive plan of care for his/her diabetes.</p> <p>4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.</p> <p>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.</p>	
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