AAA Elite Medical Equipment, Inc.
1839 Central Ave., Albany, NY 12205
Tel: (518)459-0000 Fax: (518)459-2420

Statement of Certifying Physician for Therapeutic Footwear

(The certifying physician must be a M.D. or D.O caring for the patient's diabetic condition and may be different from the prescribing physician.)

Patient name: _____D.O.B.: _____

Medicare#:_____

I certify that the following statements are true:

1) This patient has diabetes mellitus

2) This patient has one or more of the following conditions: (check all that apply)

_____History of partial or complete foot amputation
_____Foot deformity
_____History of pre-ulcerative callous
_____Poor circulation
_____Peripheral neuropathy w/ callous formation
_____Previous ulcer(s)

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4) This patient needs special shoes and/or D.M. insole because of their diabetic condition.

Certifying Physician Information (must be a M.D. or D.O)

***Physician name (printed):_____ NPI:_____**

***Signature_____Date_____**

Address:_____

_____Phone._____
(City) (State) (Zip Code)

Rx Form for Therapeutic Footwear

__Extra Depth D.M. shoes __Custom D.M. shoes __PreFab D.M. insole _1_2_3 __ Custom D.M. Insole _1_2_3

Additions & Accommodations:_____

***Physician name (printed):_____ NPI:_____**

***Signature_____Date_____**

Address:_____

_____Phone-._____
(City) (State) (Zip Code)