STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

Certificate of Medical Necessity for Diabetic Shoes

Name: _________________________________ DOB: ___________________________

MID: ___________________________________

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (**Circle all that apply**):
   a) History of partial or complete amputation of the foot
   b) History of previous foot ulceration
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   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.

Prescriber Signature: ____

Date Signed: _________________________ NPI: ___________________________

Prescriber name (printed – **MUST BE AN M.D. OR D.O.**)

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Prescriber address: ____

Prescriber telephone #: _____________________________________

Proof of medical necessity is valid for 12 months from the date of issue.