

STATE OF OKLAHOMA
Oklahoma Health Care Authority
Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

Member ID Number: _____

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.

Physician Signature: _____

Date Signed: _____

Physician name (printed):

Physician address:
