Date: [INSERT DATE]

Patient Name: [INSERT PATIENT NAME]

Date of Birth: [INSERT PATIENT DOB]

Dear Dr. [INSERT NAME],

Physical examination of the above patient revealed that [PATIENT NAME] has the conditions listed on the enclosed form and therefore qualifies for footwear and inserts under the Medicare Therapeutic Shoe Bill. This preventative program was established for at=risk patients, with or without a history of foot ulceration.

Medicare guidelines require that the physician who is managing the patient’s condition certify the patient of footwear and inserts. Medicare also requires that the certifying physician (MD or DO) review, sign, and date a copy of the Podiatric records which verify the presence of the qualifying conditions indicated on the certifying physician statement.

We ask you to please SIGN THE CERTIFYING STATEMENT AND THE PODIATRIC NOTES and fax them to [INSERT FAX NUMBER]. Please place this information in the patient’s chart. If you have questions concerning this patient, please do not hesitate to call me. Thank you for your cooperation.

Sincerely,

[NAME]