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:
_________________________________________________
_________________________________________________
_________________________________________________

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