Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: THERAPEUTIC FOOTWEAR FOR INDIVIDUALS WITH DIABETES

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)

☐ This individual has diabetes mellitus.

☐ The following conditions of coverage are met.

- ☐ An entire foot (i.e., the foot for which footwear is not being prescribed) has been amputated.
- ☐ Part of either foot has been amputated.
- ☐ In either foot, the individual has a history of
  - ☐ ulceration.
  - ☐ pre-ulcerative calluses.
  - ☐ peripheral neuropathy with evidence of callus formation.
  - ☐ foot deformity.
  - ☐ poor circulation.

☐ This individual is being treated for diabetes under a comprehensive plan of care by the prescriber.

☐ Therapeutic footwear is medically necessary for this individual because of diabetes.

☐ All relevant information is documented in this individual's medical record.

Comments or clinical information

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.