DMEnsion
P.O. Box 81460, Rochester, MI 48308-1460
Telephone: (877) 345-4774 Fax: (248) 844-8614

Date: **Requestor:**
To: **Fax Number:**
Patient Name: **I.D. Number:**

Certificate of Medical Necessity (CMN) for Therapeutic Shoes

We require a specialized prescription for the **Therapeutic Shoes** ordered for the above listed patient. Once finished, fax the prescription back to us using the fax number appearing above. We thank you in advance for assisting us in qualifying your patient for the requested piece of home medical equipment.

Please answer all of the questions listed below.	**Y** for Yes **N** for No **D** for Does Not Apply

1. Does the patient have diabetes mellitus **Y N D**
   and 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 neurophathy with evidence of callus formation
   e) Foot deformity
   f) Poor circulation
   g) Hemiplegia/Hemiparesis
   h) Foot drop

2. I am treating this patient under a comprehensive plan of care for his/her condition? **Y N D**

3. The patient needs special shoes (extra depth or custom-molded shoes) because of his/her diabetes?

4. Does the patient currently wear a leg brace? **Y N D**

5. Will the shoe be attached to a brace? **Y N D**

Clinical Rationale ____
____

Contact Name:_________________________ **Phone Number**: __________________

___________________________ ______/______/_____
Physician Signature **Date**
(Stamps are not acceptable)