Reset Form

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
DIABETIC FOOTWEAR

Instructions: *The Certificate of Medical Necessity (CMN) must be used for Diabetic Footwear under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.*

Name of Consumer	Consumer OH Medicaid Number		Consumer DOB
Consumer Address	City	State	Zip

Section A - Must be completed by Prescriber

I certify that all of the following statements are true:

1) This consumer has diabetes mellitus-ICD-9 code **(Five digit ICD-9 Diagnosis Code Required 250.00-250.93)**:
2) This consumer has one or more of the following conditions **(Check 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 consumer under a comprehensive plan of care for his/her diabetes.
4) This consumer needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.
5) The above information is documented in the consumer's medical record.

Additional relevant clinical information:

Section B - Prescriber Attestation and Signature/Date

Prescriber Name *(printed)*

I certify that I am the prescriber identified above. I certify that the information contained on this document of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date
Ohio Medicaid Legacy #	NPI #