



DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY  
DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL Questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other, please describe:

[Empty text box for describing other requestor]

Are you a VA Healthcare provider?  Yes  No

Is the Veteran regularly seen as a patient in your clinic?  Yes  No

Was the Veteran examined in person?  Yes  No

If no, how was the examination conducted?

[Empty text box for describing examination method]

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

[Large empty text box for identifying evidence reviewed]

**SECTION I - DIAGNOSIS**

DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH DIABETIC PERIPHERAL NEUROPATHY?

YES  NO

IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO DIABETIC PERIPHERAL NEUROPATHY:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO DIABETIC PERIPHERAL NEUROPATHY, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DOES THE VETERAN HAVE DIABETES MELLITUS TYPE I OR TYPE II?

YES  NO

2B. DESCRIBE THE HISTORY (including cause, onset and course) OF THE VETERAN'S DIABETIC PERIPHERAL NEUROPATHY

2C. DOMINANT HAND

RIGHT  LEFT  AMBIDEXTROUS

**SECTION III - SYMPTOMS**

3A. DOES THE VETERAN HAVE ANY SYMPTOMS ATTRIBUTABLE TO DIABETIC PERIPHERAL NEUROPATHY?

YES  NO (If "Yes," indicate symptoms' location and severity) (Check all that apply):

CONSTANT PAIN (may be excruciating at times)

RIGHT UPPER EXTREMITY:  None  Mild  Moderate  Severe

LEFT UPPER EXTREMITY:  None  Mild  Moderate  Severe

RIGHT LOWER EXTREMITY:  None  Mild  Moderate  Severe

LEFT LOWER EXTREMITY:  None  Mild  Moderate  Severe

INTERMITTENT PAIN (usually dull)

RIGHT UPPER EXTREMITY:  None  Mild  Moderate  Severe

LEFT UPPER EXTREMITY:  None  Mild  Moderate  Severe

RIGHT LOWER EXTREMITY:  None  Mild  Moderate  Severe

LEFT LOWER EXTREMITY:  None  Mild  Moderate  Severe

PARESTHESIAS AND/OR DYSESTHESIAS

RIGHT UPPER EXTREMITY:  None  Mild  Moderate  Severe

LEFT UPPER EXTREMITY:  None  Mild  Moderate  Severe

RIGHT LOWER EXTREMITY:  None  Mild  Moderate  Severe

LEFT LOWER EXTREMITY:  None  Mild  Moderate  Severe

NUMBNESS

RIGHT UPPER EXTREMITY:  None  Mild  Moderate  Severe

LEFT UPPER EXTREMITY:  None  Mild  Moderate  Severe

RIGHT LOWER EXTREMITY:  None  Mild  Moderate  Severe

LEFT LOWER EXTREMITY:  None  Mild  Moderate  Severe

OTHER SYMPTOMS (Describe symptoms, location and severity):

**SECTION IV - NEUROLOGIC EXAM**

**4A. STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:**

0/5 No muscle movement		2/5 No movement against gravity		4/5 Less than normal strength
1/5 Visible muscle movement, but no joint movement		3/5 No movement against resistance		5/5 Normal strength

  

<input type="checkbox"/> All normal	Elbow Flexion	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Elbow Extension	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Wrist Flexion	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Wrist Extension	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Grip	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Pinch (thumb to index finger)	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Knee Extension	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Knee Flexion	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Ankle Plantar Flexion	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Ankle Dorsiflexion	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5

**4B. DEEP TENDON REFLEXES (DTRs) - RATE REFLEXES ACCORDING TO THE FOLLOWING SCALE:**

0 - Absent	2+ Normal	4+ Increased with clonus
1+ Decreased	3+ Increased without clonus	

  

<input type="checkbox"/> All normal	Biceps	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
		LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Triceps	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
		LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Brachioradialis	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
		LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Knee	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
		LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Ankle	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
		LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

**4C. LIGHT TOUCH/MONOFILAMENT TESTING RESULTS**

<input type="checkbox"/> All Normal	Shoulder area	RIGHT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
		LEFT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Inner/outer forearm	RIGHT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
		LEFT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Hand/fingers	RIGHT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
		LEFT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Knee/thigh	RIGHT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
		LEFT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Ankle/lower leg	RIGHT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
		LEFT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Foot/toes	RIGHT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
		LEFT:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

**4D. POSITION SENSE (grasp index finger/great toe on sides and ask patient to identify up and down movement)**

<input type="checkbox"/> Not tested	RIGHT UPPER EXTREMITY	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	LEFT UPPER EXTREMITY	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	RIGHT LOWER EXTREMITY	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	LEFT LOWER EXTREMITY	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

**SECTION IV - NEUROLOGIC EXAM (Continued)**

4E. VIBRATION SENSATION (place low-pitched tuning fork over DIP joint of index finger/IP joint of great toe)

- |                                     |                       |                                 |                                    |                                 |
|-------------------------------------|-----------------------|---------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Not tested | RIGHT UPPER EXTREMITY | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |
|                                     | LEFT UPPER EXTREMITY  | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |
|                                     | RIGHT LOWER EXTREMITY | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |
|                                     | LEFT LOWER EXTREMITY  | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |

4F. COLD SENSATION (test distal extremities for cold sensation with side of tuning fork)

- |                                     |                       |                                 |                                    |                                 |
|-------------------------------------|-----------------------|---------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Not tested | RIGHT UPPER EXTREMITY | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |
|                                     | LEFT UPPER EXTREMITY  | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |
|                                     | RIGHT LOWER EXTREMITY | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |
|                                     | LEFT LOWER EXTREMITY  | <input type="checkbox"/> Normal | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |

4G. DOES THE VETERAN HAVE MUSCLE ATROPHY?

- YES     NO

(If muscle atrophy is present, indicate location): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(For each instance of muscle atrophy, provide measurements in cm between normal and atrophied side, measured at maximum muscle bulk: \_\_\_\_\_ cm.)

4H. DOES THE VETERAN HAVE TROPHIC CHANGES (*characterized by loss of extremity hair, smooth, shiny skin, etc.*) ATTRIBUTABLE TO DIABETIC PERIPHERAL NEUROPATHY?

- YES     NO (If "Yes," describe):

**SECTION V - SEVERITY**

NOTE: Based on symptoms and findings from Sections III and IV, complete Items a and b below to provide an evaluation of the severity of the Veteran's diabetic peripheral neuropathy.

NOTE: For VA purposes, the term "incomplete paralysis" indicates a degree of lost or impaired function substantially less than the description of complete paralysis that is given with each nerve. If the nerve is completely paralyzed, check the box for "complete paralysis". If the nerve is not completely paralyzed, check the box for "incomplete paralysis" and indicate severity. For VA purposes, when nerve impairment is wholly sensory, the evaluation should be mild, or at most, moderate.

5A. DOES THE VETERAN HAVE AN UPPER EXTREMITY DIABETIC PERIPHERAL NEUROPATHY?

- YES     NO

(If "Yes," indicate nerve affected, severity and side affected)

RADIAL NERVE (musculospiral nerve)

(NOTE: Complete paralysis (hand and fingers drop, wrist and fingers flexed; cannot extend hand at wrist, extend proximal phalanges of fingers, extend thumb or make lateral movement of wrist; supination of hand, elbow extension and flexion weak, hand grip impaired.)

- RIGHT:     Normal     Incomplete paralysis     Complete paralysis  
 (If incomplete paralysis is checked, indicate severity):     Mild     Moderate     Severe

- LEFT:     Normal     Incomplete paralysis     Complete paralysis  
 (If incomplete paralysis is checked, indicate severity):     Mild     Moderate     Severe

MEDIAN NERVE

(NOTE: Complete paralysis (hand inclined to the ulnar side, index and middle fingers extended, atrophy of thenar eminence, cannot make fist, defective opposition of thumb, cannot flex distal phalanx of thumb; wrist flexion weak.)

- RIGHT:     Normal     Incomplete paralysis     Complete paralysis  
 (If incomplete paralysis is checked, indicate severity):     Mild     Moderate     Severe

- LEFT:     Normal     Incomplete paralysis     Complete paralysis  
 (If incomplete paralysis is checked, indicate severity):     Mild     Moderate     Severe

ULNAR NERVE

(NOTE: Complete paralysis ("griffin claw" deformity, atrophy in dorsal interspaces, thenar and hypothenar eminences; cannot extend ring and little finger, cannot spread fingers, cannot adduct the thumb; wrist flexion weakened.)

- RIGHT:     Normal     Incomplete paralysis     Complete paralysis  
 (If incomplete paralysis is checked, indicate severity):     Mild     Moderate     Severe

- LEFT:     Normal     Incomplete paralysis     Complete paralysis  
 (If incomplete paralysis is checked, indicate severity):     Mild     Moderate     Severe

**SECTION V - SEVERITY (Continued)**

5B. DOES THE VETERAN HAVE A LOWER EXTREMITY DIABETIC PERIPHERAL NEUROPATHY?

YES  NO

(If "Yes," indicate nerve affected, severity and side affected)

SCIATIC NERVE

(NOTE: Complete paralysis (foot dangles and drops, no active movement of muscles below the knee, flexion of knee weakened or lost.)

RIGHT:  Normal  Incomplete paralysis  Complete paralysis

(If incomplete paralysis is checked, indicate severity):

Mild  Moderate  Moderately Severe  Severe, with marked muscular atrophy

LEFT:  Normal  Incomplete paralysis  Complete paralysis

(If incomplete paralysis is checked, indicate severity):

Mild  Moderate  Moderately Severe  Severe, with marked muscular atrophy

FEMORAL NERVE (anterior crural)

(NOTE: Complete paralysis (paralysis of quadriceps extensor muscles.)

RIGHT:  Normal  Incomplete paralysis  Complete paralysis

(If incomplete paralysis is checked, indicate severity):

Mild  Moderate  Moderately Severe

LEFT:  Normal  Incomplete paralysis  Complete paralysis

(If incomplete paralysis is checked, indicate severity):

Mild  Moderate  Moderately Severe

**SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO

IF YES, DESCRIBE (brief summary):

6B. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (6 square inches); OR ARE LOCATED ON THE HEAD, FACE OR NECK?

YES  NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: \_\_\_\_\_ MEASUREMENTS: length \_\_\_\_\_ cm X width \_\_\_\_\_ cm.

**NOTE:** An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

6C. COMMENTS, IF ANY:

**SECTION VII - DIAGNOSTIC TESTING**

**NOTE:** For purposes of this examination, electromyography (EMG) studies are rarely required to diagnose diabetic peripheral neuropathy. The diagnosis of diabetic peripheral neuropathy can be made in the appropriate clinical setting by a history of characteristic pain and/or sensory changes in a stocking/glove distribution and objective clinical findings, which may include symmetrical lost/decreased reflexes, decreased strength, lost/decreased sensation for cold, vibration and/or position sense, and/or lost/decreased sensation to monofilament testing.

7A. HAVE EMG STUDIES BEEN PERFORMED?

YES  NO

(Extremities tested):

RIGHT UPPER EXTREMITY Results:  Normal  Abnormal Date: \_\_\_\_\_

LEFT UPPER EXTREMITY Results:  Normal  Abnormal Date: \_\_\_\_\_

RIGHT LOWER EXTREMITY Results:  Normal  Abnormal Date: \_\_\_\_\_

LEFT LOWER EXTREMITY Results:  Normal  Abnormal Date: \_\_\_\_\_

(If abnormal, describe): \_\_\_\_\_

7B. IF THERE ARE OTHER SIGNIFICANT FINDINGS OR DIAGNOSTIC TEST RESULTS, PROVIDE DATES AND DESCRIBE

**SECTION VIII - FUNCTIONAL IMPACT**

DOES THE VETERAN'S DIABETIC PERIPHERAL NEUROPATHY IMPACT HIS OR HER ABILITY TO WORK?

YES     NO    If "Yes," describe impact of the veteran's diabetic peripheral neuropathy, providing one or more examples:

**SECTION IX - REMARKS**

9. REMARKS, if any:

**SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

10A. PHYSICIAN'S SIGNATURE	10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED
10D. PHYSICIAN'S PHONE AND FAX NUMBER	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. PHYSICIAN'S ADDRESS