Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #13
AUGMENTATIVE COMMUNICATION DEVICE

Member Name		Health First Colorado ID #	

Length of Need	

Note: A questionnaire is not an assessment tool. The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. What is the complete diagnosis with complicating factors?	
2. Is the member's speech understood less than 25% of the time by an unfamiliar listener?	□ Yes □ No
3. Is lack of speech: a. Is improvement expected without the aid of an ACD? b. If yes, how soon?	□ Permanent □ Temporary □ Yes □ No
4. Does member have ability to effectively use a communication device (including tablet)? a. Explain.	□ With caregiver help □ Without caregiver help
5. Has the member received a course of speech therapy? a. If yes, notate length of time and frequency. b. Explain.	□ Yes □ No **Length of time** **Frequency**
6. Is this request for the initial two (2) month trial period?	□ Yes □ No
7. Is this request post two (2) month trial period? a. If yes, what devices were trialed?	□ Yes □ No
8. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Note: A separate PAR must be submitted for each trial period and purchase.

Print Medical Professional Name _____

Medical Professional Signature _____

Date _____