COLORADO
Department of Health Care Policy & Financing

Acentra HEALTH

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 #2
PRESSURE RELIEF MATTRESS

Member Name		Health First Colorado ID #	

Length of Need		End Date		Height		Weight	

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. Does the member currently have any pressure sores? State location and give a complete description which includes risk factors, i.e. Braden scale risk assessment score, multiple stage II on trunk or pelvis or any stage III or IV?	☐ Yes ☐ No
3. Does the member have a Braden scale risk assessment score? If yes, please state the score.	☐ Yes ☐ No
4. Is the member presently on a pressure-relief system or been on an ulcer treatment program that has included the use of a non powered pressure reducing overlay/mattress or alternating pressure pad?	☐ Yes ☐ No ☐ Pressure Relief System ☐ Ulcer Treatment Program
5.What past and current equipment has been trailed/ utilized?	
6.. Why isn't the current equipment (if any) meeting the member's needs?	
7.What type of mattress does the member require based on the member's past and present skin condition history? Describe which group mattress is required based on the above information.	
8. Explain in detail the member's ability to stand, ambulate, transfer and change positions.	
9. How many hours per day is this member in bed?	

10. If this member has a history of skin breakdown, please explain.	
11.Has there been any surgical intervention?	☐ Yes ☐ No
12. Has member's nutritional status been assessed? If so, please explain their nutritional intake.	
13.Supply any additional information that will assist us in determining **medical necessity** for this request:	
14. Please remember a signed order and face-to-face visit is required on all of these requests in addition to this questionnaire.	

Print Prescriber Name _____

Prescriber Signature _____

Date_____