# QUESTIONNAIRE #4

## SEAT LIFT

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Health First Colorado ID #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Length of Need</th>
<th>End Date</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>

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 this request for an independent seat lift device or as a component of a power wheelchair?**
   - □ Independent Seat
   - □ Component of Power Wheelchair Lift Device
   
   **Note:** If wheelchair component, complete DME Questionnaire #17.

3. **Is the seat lift mechanism intended to allow member to perform activities of daily living independently?**
   - □ Yes □ No

4. **Is the member completely incapable of standing from any chair in the home?**
   - □ Yes □ No
   
   If yes, is member able to ambulate independently with or without aides (cane, walker, etc.)?
   - □ Yes □ No

5. **What past and current equipment has been utilized?**

6. **Why isn’t the current equipment (if any) meeting the member’s needs?**

7. **Supply any additional information that will assist us in determining medical necessity for this request:**

---

Print Prescriber Name ____________________________

Prescriber Signature ____________________________

Date ____________________________

Revised June 2021

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

hcpf.colorado.gov