# QUESTIONNAIRE #5
## STANDING DEVICES

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Health First Colorado ID #</th>
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<tr>
<th>Length of Need</th>
<th>End Date</th>
<th>Height</th>
<th>Weight</th>
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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. Describe equipment being requested.

3. What past and current equipment has been utilized?

4. Is the member able to operate the stander independently? □ Yes □ No

5. Does the member use a wheelchair for mobility? □ Yes □ No

6. Does the stander have adequate supports anterior and posterior? □ Yes □ No

7. Does the stander have adequate supports to laterally position the person in a symmetrical aligned standing? □ Yes □ No

8. Does the stander have enough adjustment to allow for individual fit and for growth changes? □ Yes □ No

9. What is the height range and weight capacity of the stander?
   - Height Range From: To:
   - Weight Capacity From: To:

10. What makes the model chosen advantageous in changing positions?

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

Print Prescriber Name ________________________________

Prescriber Signature ________________________________

Date ________________________________

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