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 #5
STANDING DEVICES

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. 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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