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 #7
APNEA MONITOR

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. How frequently do apneic episodes occur? Dates:	
3. Is apnea monitoring?	□ Continuous □ At night only □ During feedings
4. List all documented apneic episodes during the initial 6-month monitoring period.	
5. Has the member been hospitalized due to apneic episodes or related diagnosis? If yes, what dates?	□ Yes □ No
6. Does the member use oxygen? If yes, what is the flow?	□ Yes □ No
7. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____