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 #11
ADULT ORTHOTICS and PROSTHETICS - ADULTS 21+

Member Name		Health First Colorado ID #	

Start 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. What change in the member's condition is anticipated if the equipment is provided?	□ Problem Correction □ Problem Alleviation □ Prevention of associated problems □ Potential of avoiding surgery with use of orthotics or prosthetic
Questions Specific to Prostheses	
3. What is the functional level as defined by Medicare?	Levels: □ 1 □ 2 □ 3 □ 4 □ 5
4. Is this a replacement?	□ Yes □ No
a. If replacement, in what year was the current prosthesis issued?	**Year**
b. If new prosthesis, when was the amputation/ surgery performed?	**Month** **Year**
Questions Specific to Orthosis	
5. Is this a replacement?	□ Yes □ No
a. If replacement, when was the current orthosis issued?	**Year**
6. Is this orthosis?	□ Pre-fabricated **or** □ Custom
7. What is the reason a pre-fabricated device is not appropriate?	
8. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____