



Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219

ColoradoPAR Program

Medical Review Department

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QUESTIONNAIRE #13 AUGMENTATIVE COMMUNICATION DEVICE

Member Nam	e	Health First	t Colora	do ID #		
Length of Nee	ed					
necessity. Cor	ionnaire is not an assessment tool. The informat	or Authoriza				ne medical
1. What	is the complete diagnosis with complicating factor	ors?				
	member's speech understood less than 25% of unfamiliar listener?	the time	Yes	□ No		
a. Is	k of speech: s improvement expected without the aid of an AG yes, how soon?	CD?		anent 🗆 No	Temporary	
device	member have ability to effectively use a commune (including tablet)? xplain.	nication 🗆		caregiver out caregiv		
a. If	ne member received a course of speech therapy yes, notate length of time and frequency. xplain.			□ No of time ncy		
6. Is this	s request for the initial two (2) month trial period	ქ? □	Yes	□ No		
7. Is this	request post two (2) month trial period? yes, what devices were trialed?		Yes	□ No		
	y any additional information that will assist us in mining medical necessity for this request:					
Note : A separ	rate PAR must be submitted for each trial period	and purcha	ase.			
Print Medical I	Professional Name					
Medical Profes	ssional Signature					
Date						

