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 #14
MECHANICAL HIGH FREQUENCY CHEST WALL OSCILLATION

Member Name		Health First Colorado ID #	

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. Has the member received The Vest ™ treatment in the past? a. If yes, how recently was treatment given (in months)? b. For how long? c. If treatments were discontinued, why?	□ Yes □ No □ Current □ 1 -6 months ago □ More than 6 months ago **Length of time**
3. Provide hospitalization history (in the past year prior to The Vest ™ treatment for members currently using system):	**Admit Date** **Diagnosis** **Admit Date** **Diagnosis** □ Check if additional information is included
4. Manual percussion therapy (in past 6 months):	**Time per day prescribed/required** **Length of Time** **Primary Caregiver** **Results/Comments**
5. Flutter therapy (in past 6 months):	**Time per day prescribed/required** **Length of Time** **Primary Caregiver** **Results/Comments**

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<tr><td>6. Other mechanical therapy (in past 6 months)</td><td>
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<tr><td>Time per day prescribed/required</td><td></td><td>Length of Time</td><td></td></tr>
<tr><td>Primary Caregiver</td><td colspan="3"></td></tr>
<tr><td>Results/Comments</td><td colspan="3"></td></tr>
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<tr><td>7. Supply any additional information that will assist us in determining medical necessity for this request:</td><td></td></tr>
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Print Prescriber Name _____

Prescriber Signature _____

Date _____