**QUESTIONNAIRE #15**
**WHEELCHAIR TILT / RECLINE DEVICE**

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<th>Member Name</th>
<th>Health First Colorado ID #</th>
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<th>Length of Need</th>
<th>Height</th>
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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. Does the member sit in a wheelchair more than four hours without the ability to change positions?
   a. If yes, describe.  
   □ Yes □ No

3. Describe in detail the member’s ability to stand, ambulate, transfer and change positions.

4. Does the member have or had an alteration in skin integrity?
   **Note:** Complete a medical necessity letter with this information.
   □ Yes □ No

5. Describe the member's living environment:
   Is the environment equipped to accommodate a tilt/recline feature?  
   □ Yes □ No

6. Supply any additional information that will assist us in determining **medical necessity** for this request:

Print Prescriber Name ____________________________________________

Prescriber Signature ____________________________________________

Date ____________________________

Revised August 2021

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

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