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 #15
WHEELCHAIR TILT / RECLINE DEVICE

Member Name		Health First Colorado ID #	

Length of Need		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. 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 _____