Prior Authorization Request
5802 Benjamin Center Dr., Suite 105
Tampa, FL 33634

ColoradoPAR Program
Medical Review Department

Phone: 1-888-801-9355
Fax: 1-866-940-4288

QUESTIONNAIRE #15
WHEELCHAIR TILT / RECLINE DEVICE

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
		Weight:	

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

Question	Response
1) What is the complete diagnosis with complicating factors:	
2) Does the client sit in a wheelchair more than four hours without the ability to change positions? a) If yes, explain.	☐Yes ☐No
3) Explain in detail the client's ability to stand, ambulate, transfer and change positions.	
4) Does the client have or had an alteration in skin integrity? **Note: Describe in detail within letter of medical necessity.**	☐Yes ☐No
5) Describe the client's living environment a) Is the environment equipped to accommodate a tilt/recline feature?	☐Yes ☐No
6) Please supply any additional information that will assist us in determining **medical necessity** for your request:	

Print Prescriber Name __________________________________

Prescriber Signature __________________________________ Date _______________

Revision Date: 09/15