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 #17
POWER SEAT LIFT COMPONENT ONLY

Member Name		Health First Colorado ID #	

Length of Need		Height	
End Date		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 member have caregiver support? a. If yes, how many hours per day?	☐ Yes ☐ No _____ hours per day
3. Is the seat lift mechanism intended to allow member to perform activities of daily living independently?	☐ Yes ☐ No
4. What past and current equipment has been utilized?	
5. Why isn't the current equipment (if any) meeting the member's needs?	
6. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____