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 #19
Enclosed/Safety Beds

Member Name		Health First Colorado ID #	

Length of Need		End Date		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. Does the member have one of the following diagnoses? Please select all that apply.	□ Traumatic Brain Injury □ Cerebral Palsy □ Seizure Disorder □ Severe Behavioral Disorder
2. Does the member experience cognitive and communication impairment?	□ Yes □ No
3. Does the member experience daily tonic-clonic seizure activity, uncontrolled movement related to a diagnosis, and or self-injurious behavior? Please select all that apply.	☐ Yes □ No □ Daily seizure activity □ Uncontrolled movement □ Self-injurious behavior
4. Has the member demonstrated at risk mobility, such as attempting to climb out of bed? If yes, please include what the behaviors are.	□ Yes ☐ No Explain:
5. Have there been previous attempts of using less invasive and less costly measures?	☐ Yes ☐ No
6. Why haven't less invasive and less costly measures been effective in keeping the member safe?	
7. Is the member an adult experiencing confusion or dementia?	☐ Yes ☐ No

8. Is the intent to restrain the member because of behavioral concerns?	☐ Yes ☐ No
9. Please confirm that the family/caregiver has been trained on the proper and safe use of the bed	☐ Yes ☐ No
10. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date_____

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