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 #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 □ Developmental Disability □ Severe Behavioral Disorder
2. Does the member experience cognitive, behavioral, or communication impairment posing safety risks?	☐ 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. Does the member have mobility risks and/or has demonstrated an increased risk for falls? If yes, please indicate what behaviors put them at risk.	☐ Yes ☐ No Explain:
5. Have there been previous attempts at using less invasive and less costly measures than a safety bed? 5. a. If so, what were the specific measures attempted and what made them ineffective in keeping the member safe?	☐ ☐ □ Yes □ No
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 medical documentation needed to support the responses to the questionnaire to assist with determining **medical necessity** for this request:	

Print Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____