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 #1
HOSPITAL BED

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
End Date:		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).

1) What is the complete diagnosis with complicating factors:	
2) How many hours per day is this client in bed?	
3) What is the level of the client's mobility and or use of adaptive devices?	
4) Describe equipment being requested.	
5) What past and current equipment has been utilized?	
6) Why isn't the current equipment (if any) meeting the client's needs?	
7) Does the patient require positioning not feasible in a standard bed?	☐Yes ☐No
8) If request is for a semi or fully electric hospital bed, explain why a manual hospital bed will not provide for this client's needs.	
9) Can the client work the controls of an electric bed independently?	☐Yes ☐No
10) Can the client change positions independently?	☐Yes ☐No
11) Is condition:	☐Permanent ☐Temporary
12) Is the client left alone for long periods of time? a) If so, how many hours per day?	☐Yes ☐No
13) Is a caregiver available to assist this client in changing position? a) If so, how many hours per day?	☐Yes ☐No
14) Is the client's primary caregiver able to adjust the bed manually? a) If no, please explain why.	☐Yes ☐No
15) What is the transfer method?	
16) 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