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 #3
LIFTS

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) What type of lift is necessary to meet the client's needs? Please explain.	☐Electric ☐Manual
3) What past and current equipment has been utilized?	
4) Why isn't the current equipment (if any) meeting the client's needs?	
5) Does this client's condition require assistance for transfers?	☐Yes ☐No
6) Does the caregiver have the ability to perform transfers with the requested equipment?	☐Yes ☐No
7) To what degree can this client assist the caregiver with transfers?	
8) Can this client ambulate? a) If yes, how far and with what degree of assistance?	☐Yes ☐No
9) Describe the client's living environment a) Is the environment equipped to accommodate a lift system? b) Dimensions of space where equipment is to be utilized. (Include pictures)	☐Yes ☐No
10) Is the need for this equipment:	☐Permanent ☐Temporary
11) Please supply any additional information that will assist us in determining **medical necessity** for this request:	

***Note: Permanently affixed ceiling lift is a home modification and not a Durable Medical Equipment benefit. For additional information contact Long Term Care benefits listed in Appendix D.**

Print Prescriber Name _____

Prescriber Signature _____ Date _____

Revision Date: 09/15