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 #4
SEAT LIFT

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) Is this request for an independent seat lift device or as a component of a power wheelchair? ***Note: If wheelchair component complete Questionnaire 17.**	☐ Independent Seat ☐ Component of Power Wheelchair Lift Device
3) Is the seat lift mechanism intended to allow client to perform activities of daily living independently?	☐Yes ☐No
4) Is the client completely incapable of standing from any chair in the home? a.) If yes, is client able to ambulate independently with or without aides (cane, walker, etc.)?	☐Yes ☐No
5) What past and current equipment has been utilized?	
6) Why isn't the current equipment (if any) meeting the client's needs?	
7) 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