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 #5
STANDING DEVICES

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) Describe equipment being requested.	
3) What past and current equipment has been utilized?	
4) Is the patient able to operate the stander independently?	☐Yes ☐No
5) Does the patient use a wheelchair for mobility?	☐Yes ☐No
6) Does the stander have adequate supports anterior and posterior?	☐Yes ☐No
7) Does the stander have adequate supports to laterally position the person in a symmetrical aligned standing?	☐Yes ☐No
8) Does the stander have enough adjustment to allow for individual fit and for growth changes?	☐Yes ☐No
9) What is the height range and weight capacity of the stander?	**Height Range** *From:* *To:* **Weight Capacity** *From:* *To:*
10) What makes the model chosen advantageous in changing positions?	
11) 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