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 #7
APNEA MONITOR

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
		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 frequently do apneic episodes occur? a.) Dates:	
3) Is apnea monitoring:	☐ Continuous ☐ At night only ☐ During feedings
4) List all documented apneic episodes during the initial 6- month monitoring period:	
5) Has the client been hospitalized due to apneic episodes or related diagnosis? a.) If yes, what dates?	☐ Yes ☐ No
6) Does the client use oxygen? a.) If yes, what is the flow?	☐ Yes ☐ No
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