## QUESTIONNAIRE #11
### ADULT ORTHOTICS and PROSTHETICS—ADULTS 21+

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Colorado Medicaid ID #:</th>
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<td>Start Date:</td>
<td>Height:</td>
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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:**
   - Problem Correction
   - Problem Alleviation
   - Prevention of associated problems
   - Potential of avoiding surgery with use of orthotics or prosthetic

2) **What change in the client's condition do you anticipate if the equipment is provided?**
   - Problem Correction
   - Problem Alleviation
   - Prevention of associated problems
   - Potential of avoiding surgery with use of orthotics or prosthetic

### Questions specific to Prostheses:
3) **Functional level as defined by Medicare:**
   - Level 0
   - Level 1
   - Level 2
   - Level 3
   - Level 4

4) **Is this a replacement?**
   a.) If this is a replacement, in what year was the current prosthesis issued?
   - Yes
   - No
   
   **Year:**

   b.) If this is a new prosthesis, when was the amputation/surgery performed?
   
   **Month:**
   **Year:**

### Question specific to Orthosis:
5) **Is this a replacement?**
   a.) If this is a replacement, when was the current orthosis issued?
   - Yes
   - No

6) **Is this orthosis:**
   - Pre-fabricated
   - Custom

7) **What is the reason a pre-fabricated device is not appropriate?**

8) **Please supply any additional information that will assist us in determining medical necessity for your request:**

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Print Prescriber Name

Prescriber Signature

Date