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 #14
MECHANICAL HIGH FREQUENCY CHEST WALL OSCILLATION

Client Name:		Colorado Medicaid ID #:	

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) Has client received The Vest ™ treatment in the past? a) If yes, how recently was treatment given (in months)? b) For how long? c) If treatments were discontinued, why?	☐Yes ☐No ☐ Current ☐ 1-6 months ago ☐ More than 6 months ago **Length of Time:**
3) Hospitalization history (in the past year prior to The Vest ™ treatment for clients currently using system):	**Admit Date:** **Diagnosis:** **Admit Date:** **Diagnosis:** ☐ Check if additional information is included.
4) Manual percussion therapy (in past 6 months)	**Times per day prescribed/required:** **Length of time:** **Primary Caregiver:** **Results/Comments:**
5) Flutter therapy (in past 6 months)	**Times per day prescribed/required:** **Length of time:** **Primary Caregiver:** **Results/Comments:**
6) Other mechanical therapy (in past 6 months)	**Times per day prescribed/required:** **Length of time:** **Primary Caregiver:** **Results/Comments:**
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