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 #18
BLOOD PRESSURE UNIT/MONITOR

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) Indicate the dates and the latest three blood pressure readings of the client	**Date:** / **Reading:**
3) How frequently does the blood pressure need to be monitored?	
4) What medication(s) is the client on?	
5) If ordering an automatic monitor, please explain why a manual monitor will not meet the client's needs:	
6) Please supply any additional information that will assist us in determining **medical necessity** for your request:	

Print Prescriber Name _____

Prescriber Signature _____ Date _____