Kepro™

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #1
HOSPITAL BED

Member Name		Health First Colorado ID #	

Length of Need		End Date		Height		Weight	

The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. What is the complete diagnosis with complicating factors?	
2. How many hours per day is this member in bed?	
3. What is the level of the member's mobility and or use of adaptive devices?	
4. Describe equipment being requested (semi-electric, electric, fixed height, or variable height).	
5. What past and current equipment has been utilized?	
6. Why isn't the current equipment (if any) meeting the member's needs?	
7. Does the member require positioning not feasible in a standard bed? Please explain.	☐ Yes ☐ No Explain:
8. If request is for a semi or fully electric hospital bed, explain why a manual hospital bed will not provide for this member's needs.	Explain:
9. Does the member require facilitation of transfer to a chair, wheelchair, or standing position? Please explain.	☐ Yes ☐ No Explain:
10. Does the member require nursing care or intervention? Such as trach care, catheter care, etc. Please explain.	☐ Yes ☐ No Explain:
11. Does the member require special equipment that requires a hospital bed for use? If so, please explain.	

12. Can the member work the controls of an electric bed independently?	☐ Yes ☐ No
13. Is the member left alone for long periods of time? If so, how many hours per day?	☐ Yes ☐ No Explain:
14. Is Is the caregiver available to assist this member in changing position? If so, how many hours per day?	☐ Yes ☐ No Explain:
15. Is the member's caregiver able to adjust the bed manually? If no, explain why.	☐ Yes ☐ No Explain:
16. What is the transfer method?	
17. Supply any additional information that will assist us in determining **medical necessity** for this request:	
18. Please remember a signed order and face-to-face visit is required on all of these requests in addition to this questionnaire.	

Print Prescriber Name ______________________________

Prescriber Signature ______________________________

Date______________________________