



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
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**QUESTIONNAIRE #17
POWER SEAT LIFT COMPONENT ONLY**

Member Name		Health First Colorado ID #	
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Length of Need		Height	
End Date		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. Does member have caregiver support? a. If yes, how many hours per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ hours per day
3. Is the seat lift mechanism intended to allow member to perform activities of daily living independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. What past and current equipment has been utilized?	
5. Why isn't the current equipment (if any) meeting the member's needs?	
6. Supply any additional information that will assist us in determining medical necessity for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____

Revised September 2021

