



Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	<b>ColoradoPAR Program</b>  Medical Review Department	Phone: 1-720-689-6340  Fax: 1-800-922-3508
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**QUESTIONNAIRE #5  
STANDING DEVICES**

Member Name		Health First Colorado ID #	
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Length of Need		End Date		Height		Weight	
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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. Describe equipment being requested.					
3. What past and current equipment has been utilized?					
4. Is the member able to operate the stander independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
5. Does the member use a wheelchair for mobility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
6. Does the stander have adequate supports anterior and posterior?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
7. Does the stander have adequate supports to laterally position the person in a symmetrical aligned standing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
8. Does the stander have enough adjustment to allow for individual fit and for growth changes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
9. What is the height range and weight capacity of the stander?	Height Range	From:		To:	
	Weight Capacity	From:		To:	
10. What makes the model chosen advantageous in changing positions?					
11. Supply any additional information that will assist us in determining <b>medical necessity</b> for this request:					

Print Prescriber Name \_\_\_\_\_

Prescriber Signature \_\_\_\_\_

Date \_\_\_\_\_

Revised June 2021

