



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 #15  
WHEELCHAIR TILT / RECLINE DEVICE**

Member Name		Health First Colorado ID #	
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Length of Need		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. Does the member sit in a wheelchair more than four hours without the ability to change positions?  a. If yes, describe.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Describe in detail the member's ability to stand, ambulate, transfer and change positions.	
4. Does the member have or had an alteration in skin integrity?  <b>Note:</b> Complete a medical necessity letter with this information.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Describe the member's living environment:  Is the environment equipped to accommodate a tilt/recline feature?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Supply any additional information that will assist us in determining <b>medical necessity</b> for this request:	

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

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

Date \_\_\_\_\_

Revised August 2021

