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 #3
LIFT

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. What type of lift is necessary to meet the member's needs? Explain:	☐ Electric ☐ Manual
3. What past and current equipment has been trailed/ utilized?	
4. Why isn't the current equipment (if any) meeting the member's needs?	
5. Does this member's condition require assistance for transfers?	☐ Yes ☐ No
6. Does the caregiver have the ability to perform transfers with the requested equipment?	
7. To what degree can this member assist the caregiver with transfers?	
8. Can this member ambulate? If yes, how far and with what degree of assistance?	☐ Yes ☐ No
9. Describe the member's living environment: a) Is the environment equipped to accommodate a life system? b) Dimension of space where equipment is to be utilized and include pictures.	
10. Is the need for this equipment?	☐ Permanent ☐ Temporary
11. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Note: Permanently affixed ceiling lift is a home modification and not a Durable Medical Equipment benefit. Refer to Long Term Care benefits listed in Appendix D for additional information.

Print Prescriber Name _____

Prescriber Signature _____

Date _____

Revised September 2022