Prior Authorization Request
5802 Benjamin Center Dr., Suite 105
Tampa, FL 33634

ColoradoPAR Program
Medical Review Department

Phone: 1-888-801-9355
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QUESTIONNAIRE #11
ADULT ORTHOTICS and PROSTHETICS—ADULTS 21+

Client Name:		Colorado Medicaid ID #:	

Start Date:		Height:		Weight:	

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

1) What is the complete diagnosis with complicating factors:	
2) What change in the client's condition do you anticipate if the equipment is provided?	☐ Problem Correction ☐ Problem Alleviation ☐ Prevention of associated problems ☐ Potential of avoiding surgery with use of orthotics or prosthetic
Questions specific to Prostheses:	
3) Functional level as defined by Medicare:	☐ Level 0 ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
4) Is this a replacement?	☐ Yes ☐ No
a.) If this is a replacement, in what year was the current prosthesis issued?	**Year:**
b.) If this is a new prosthesis, when was the amputation/ surgery performed?	**Month:** **Year:**
Question specific to Orthosis:	
5) Is this a replacement?	☐ Yes ☐ No
a.) If this is a replacement, when was the current orthosis issued?	
6) Is this orthosis:	☐ Pre-fabricated **or** ☐ Custom
7) What is the reason a pre-fabricated device is not appropriate?	
8) Please supply any additional information that will assist us in determining **medical necessity** for your request:	

Print Prescriber Name _____

Prescriber Signature _____ Date _____

Revision Date: 09/15