



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 #11  
ADULT ORTHOTICS and PROSTHETICS - ADULTS 21+**

Member Name		Health First Colorado ID #	
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Start 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. What change in the member's condition is anticipated if the equipment is provided?	<input type="checkbox"/> Problem Correction <input type="checkbox"/> Problem Alleviation <input type="checkbox"/> Prevention of associated problems <input type="checkbox"/> Potential of avoiding surgery with use of orthotics or prosthetic
<b>Questions Specific to Protheses</b>	
3. What is the functional level as defined by Medicare?	Levels: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
4. Is this a replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If replacement, in what year was the current prosthesis issued?	<b>Year</b> <input type="text"/>
b. If new prosthesis, when was the amputation/ surgery performed?	<b>Month</b> <input type="text"/> <b>Year</b> <input type="text"/>
<b>Questions Specific to Orthosis</b>	
5. Is this a replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If replacement, when was the current orthosis issued?	<b>Year</b> <input type="text"/>
6. Is this orthosis?	<input type="checkbox"/> Pre-fabricated <b>or</b> <input type="checkbox"/> Custom
7. What is the reason a pre-fabricated device is not appropriate?	
8. Supply any additional information that will assist us in determining <b>medical necessity</b> for this request:	

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

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

Date \_\_\_\_\_

Revised July 2021

