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

ColoradoPAR Program
Medical Review Department

Phone: 1-888-801-9355
Fax: 1-866-940-4288

QUESTIONNAIRE #2
PRESSURE RELIEF MATTRESS

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
End Date:		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) Does the patient currently have any pressure sores? State location and give a complete description which includes risk factors, eg.Braden scale risk assessment score, multiple stage II on trunk or pelvis or any stage III or IV?	☐Yes ☐No
3) Is the patient presently on a pressure-relief system or been on an ulcer treatment program that has included the use of a non powered pressure reducing overlay/mattress or alternating pressure pad?	☐Yes ☐No ☐Pressure –Relief System ☐Ulcer Treatment Program
4) What past and current equipment has been trailed/ utilized?	
5) Why isn't the current equipment (if any) meeting the client's needs?	
6) What type of mattress does the client require based on the client's past and present skin condition history? a) Describe which group mattress is required based on the above information.	
7) Explain in detail the client's ability to stand, ambulate, transfer and change positions.	
8) How many hours per day is this client in bed?	
9) If this client has a history of skin breakdown, please explain?	
10) Has there been any surgical intervention?	☐Yes ☐No
11) Has client's nutritional status been assessed? Explain.	
12) Please supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____ Date _____

Revision Date: 09/15