**DEPARTMENT OF VERMONT HEALTH ACCESS**

**STANDER PRIOR AUTHORIZATION REQUEST FORM**

**Instructions:** Complete all fields of this form to avoid delays and denials for requested services. Submit the form to the durable medical equipment vendor. Do not use this form for stander components for a wheelchair, or for ambulatory aids, transfer devices, or lift devices that incorporate standing components.

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| --- | --- | --- | --- | --- | --- |
| **Member Information** | | | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Height: \_\_\_\_\_\_\_\_\_ | | Weight**:** \_\_\_\_\_\_\_\_\_ |
| Transfer assistance needed (minimal, moderate, maximal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Mobility devices (walker, wheelchair): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Transfer device required (slide board, lift): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
| Member’s home is able to accommodate a stander? ☐ Yes ☐ No | | | | | |
| Member requires standing position to alleviate pain, promote proper alignment, prevent contracture, promote pulmonary clearance and respiratory function, promote bowel and bladder function and digestive function, preserve skin integrity, maximize attention and interaction, and maximize function?  Yes  No | | | | | |
| Member has demonstrated the ability to tolerate a stander?  Yes  No | | | | | |
| Member has no contraindications to using a stander and all precautions have been addressed?  Yes  No | | | | | |
| Member can transfer into the stander and operate it independently or has care providers who have been trained in proper transfer into the stander and operation of the stander?  Yes  No | | | | | |
| Member cannot stand safely or with proper alignment using an ambulatory aid such as a walker or gait trainer?  Yes  No | | | | | |
| Member requires a device with growth capacity?  Yes  No | | | | | |
| Member requires electric controls because they or their care provider are unable to operate manual controls?  Yes  No | | | | | |
| Member requires a prone stander to improve upper trunk and head control, has adequate head control to safely use the device, and can tolerate a prone transfer?  Yes  No | | | | | |
| Member requires a supine stander to provide full body support and/or a less than fully upright position during standing  Yes  No | | | | | |
| Member requires an upright stander to provide lower extremity and lower trunk support and can tolerate a sit to stand transfer?  Yes  No | | | | | |
| Member requires a multi-positional stander due to fluctuating levels of fatigue, fluctuating tone, or frequent changes in medical condition  Yes  No | | | | | |
| Member requires a mobile stander to achieve medically necessary activities of daily living in various parts of the living environment that cannot be accomplished by their mobility device (for example, their wheelchair) and member is able to propel the stander independently?  Yes  No | | | | | |
| Member requires a sit to stand system to provide lower extremity, trunk, and upper body support and can tolerate transferring on to the device from a sitting position?  Yes  No | | | | | |
| Member does not also have a standing component on their wheelchair?  Yes  No | | | | | |
| **Type of Device Needed** | | | | | |
| E0637 combination sit to stand system, any size, with seat lift, with or without wheels | |  | | | |
| E0638 upright, supine, or prone stander, any size, with or without wheels | |  | | | |
| E0641 Multi-positional stander, any size, with or without wheels | |  | | | |
| E0642 Mobile stander, any size | |  | | | |
| Other (specify) | |  | | | |
| **Type of Components Needed (Check All That Apply). All components are included in the base code. Do not request generic codes for components.** | | | | | |
| Headrest  Head laterals | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Chest harness  Chest belt | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Tray | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Upper trunk lateral supports | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Lower trunk/hip lateral supports | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Alternating air pressure overlay | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ☐ Lower trunk belt | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ☐ Abduction positioning feature | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Knee supports | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Foot positioners | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Other components (specify) | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Assessment:** | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Provider professional designation:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | | | |