Clear Form Data
FILLABLE FORM

DHS-4075-ENG 10-08

Minnesota Department of **Human Services**

Minnesota Health Care Programs

Authorization Request for Standers and Accessories

NOTE: Refer to the MHCP Provider Manual for coverage policy. This form is to be used as a guideline. If more space is needed, continue answer on separate paper and indicate which question you are answering.

PATIENT'S LAST NAME	FIRST NAME	MI
MHCP RECIPIENT ID #	**DATE OF BIRTH**	

1. Patient's Diagnosis: _____

2. Height _____ Weight _____ Other info. regarding size/stature _____

3. Patient's current living arrangement and extent of ADL assistance required:
   Living Arrangement: ☐ Home ☐ Nursing Facility ☐ Group Home ☐ Assisted Living ☐ ICF/MR ☐ Board and Care

4. Describe the recipient's medical impairments and any special needs.
   _____
   _____
   _____

5. If assistance is needed by the recipient for any ADL's, list and describe their ability, how much assistance do they need and who is the caregiver providing assistance?
   _____
   _____
   _____
   Does patient have PCA services? ☐ Yes ☐ No Number of hours/day: _____
   Describe PCA responsibilities
   _____
   _____
   _____

6. Give a complete description of the recipient's functional impairments (transfers, ambulation, range of motion). How much assistance is needed?
   _____
   _____
   _____
   _____

7. Stander requested: HCPCS Code _____ Make _____
   Model _____
   What is the weight capacity and height range of this stander?
   Weight capacity _____ Height, from _____ to _____

8. Describe the medical necessity for the requested stander and list all other accessories requested and the medical necessity unique to this recipient of each:
   _____
   _____
   _____

Description	**Medical Necessity**

9. List all less costly standing alternatives tried and explain why that equipment will not meet the patient's medical needs. (i.e. other standers, gait trainers, immobilizers, kafo's, other braces, etc.) Explain what less costly standers were tried and why they were ruled out.

10. Describe patient's current standing program. Include how long they stand, all current goals, baseline status/measurements, progress toward functional goals and benefits of standing that are specific to this recipient.

11. Where will the stander be used, and the approximate duration at each location? (hrs/day and days/wk) What daily activities would require the use of a stander that could not be done in any other position:

12. List any environmental factors to consider when deciding on this specific model of stander.

13. Is the recipient able to operate the stander independently? If not, who will assist and how?

14. Describe the trial period when the patient used this or similar equipment? If so, what was the length of each session, how many days was the trial, and what specific medical and or functional benefits resulted from the trial? In what environment was the trial? Attach a copy of the standing trial log.

14a. Describe any relative impairments (range of motion, bowel/bladder/intestinal function, history of fractures or risk for bone density issues, respiratory status) that have proven to be positively changed for this recipient by passive standing.

15. List existing equipment, age of equipment, make, and model. If recipient has an existing stander, describe why it is no longer meeting the recipient's medical needs. If current stander is being replaced due to extensive repairs, give estimates on repairs needed:

16. Does the requested stander have enough adjustment to allow for modification due to recipient growth and or size changes?

17. Patient's roles and responsibilities; in the community, at work, and at home, and how the standing program is expected to affect the patient's life.

18. Approximate length of time needed: (purchase or rental)

19. If you need to rent a stander to fulfill the requirement of a trial period because a manufacturer's demo is not available, please indicate that here.

20. Any additional information that would be useful in evaluating this request.

NAME OF COMPANY	NPI
SIGNATURE OF EQUIPMENT SPECIALIST	DATE
SIGNATURE OF PT/OT/OTHER PROFESSIONAL INVOLVED IN EVALUATION AND CREDENTIALS EVALUATION REQUIRED FOR STANDER AUTHORIZATIONS	DATE
SIGNATURE OF PHYSICIAN VERIFYING INFORMATION	DATE
ADDRESS OF PHYSICIAN	PHONE NUMBER ( )

Stander providers return completed stander form and authorization request form to:

CDMI (Care Delivery Management, Inc.)
PO Box 64265, R3-49
St. Paul, MN 55164-0560

FAX: (651) 662-7459