

**Request for Use of University Clinic or Hospital Services**

***Study Type:***  Clinical Trial (including Phase I Trials)  Non-therapeutic research or Observational trial ☐ CED (Coverage with Evidence Development)

***Study Funding: ☐ Industry (50% off) ☐ Non-Profit (60% off) ☐ Federal or Federal pass-through (discount varies, generally close to Medicare rate)***

***☐ Internal/Department funded***

***Review type:***  PAF Signature Request  Preliminary Budget Review

***Inpatient services pricing requested:***  No ☐ Yes

***Expedited review: If no procedures (clinic, lab, pathology, radiology, hospital, room, etc) will be billed to the sponsor, check here:*** ☐

***Study Information***

|  |  |  |
| --- | --- | --- |
| PI Name: | Phone: | Email: |
| Coordinator: | Phone: | Email: |
| Dept: | Program Code: | Sponsor: |
| Study Title: | | PAF # (if known): |

***Budget Information for Items that will be BILLED to SPONSOR.***

If a specific CDM or CPT code can be listed for the procedure, please do so. Otherwise include your best narrative description.

*KEEP IN MIND*: Study discounts will be applied in the billing system ***at the time of service***, so it is best to budget above the discount rate, in case prices have risen by the time your study is underway. If preparing a multi-year budget, please budget for increases in rates.

Use of either the ***Clinical Research Center*** or the ***Center for MR Research*** requires approval from those units. Please attach a copy of your authorization.

*NOTE: If pro fees are normally billed for the medical procedure through regular methods such as patient accounts or WWT AND you do not plan to bill them that way on this project (i.e., for Federal Grants they bill as effort), please check the box in the last column and attach a description of your plan for pro-fees or any arrangements you have made (including waiver. Pro fees billed to research/grant accounts by WWT are discounted at 50%, regardless of study type.  
Proposed Sponsor Price = the price you plan to charge the sponsor. If you don’t have a price in mind yet, leave blank and UI Health will return a price*

| **CDM or CPT Code** | **Procedure/Service Description** | **# of Subjects** | **# per Subject** | **Medical Service Location** | **Proposed Sponsor Price** | **Pro fees billed non-standard** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |