Clinical Trial Office _____ _____

Signature **Date**

HBO/PBO Use only Account

#_____

Grants and Clinical Trials
Agreement for Institutional Account Billing

A. Type of Account:

	Grant/Study	Clinical Trial	Contract/Other
Government			
Non-Government			

B. Account Information:

IRB#: _____

Account Name: _____

AKA Names: _____

_____

Billing Address: _____

_____

_____

_____

Responsible Person Name: _____ Phone Number: _____

C. Additional Information for Grant/Study:

Principal Investigator: _____ Effective Date: _____

Grant Number: _____ Expiration Date: _____

PT#:_____

Study CR/RN Name_____ Phone Number_____

Email Address_____

Does this trial involve, or have the potential to involve Medicare Beneficiaries as participants? Y/N

Have you contact the Clinical Trial Office and completed the Medicare Cost Coverage Analysis for assistance in completing this form? Y/N

IDE Trials: Is this device provided free of charge to us? Y/N (NOTE: If the answer is yes, then the IDE chares must be billed as non-covered). In the event there is a recalled on the device you must immediately contact the Clinical Trial Office.

FDA Approved Y/N
Attached FDA Approval Letter; CMS Approval Letter; Local/Regional CMS Fiscal Intermediary Approval Letter.

D. Billing Instructions:

☐ PO# _____
☐ Bill Grant/Study Only
☐ Government Funded Grant/Study (Must be billed to Institutional Account. Can't bill both Patient's Insurance and Grant.)

IMPORTANT NOTE: To properly establish this Account, please submit a "contract" providing billing instructions to include explanation of services, list of patients, and choice of monthly itemized statement or individual claim for MCV Physicians. MCV Hospital will bill on UB-04 per service.

At what clinic or registration site will the patient/specimen be seen (registered)?

Does a new adjustment code need to be established for the services to be provided?
Yes_____ No_____

E. Need a monthly listing of all Patients in study with the following information. Patient's Name , MRN, Service Date and Name of Study. (See Attached Spreadsheet)

F. Billing Agreement:

Agreement is made between _____ (PI/Department) and MCV Hospitals/Physicians regarding reimbursement for professional services rendered on behalf of the above mentioned organization or Grant/Study. Payment in full to MCV Hospitals/Physicians is due upon receipt of our statement. Balances over 45 days old are considered past due. In the event that a Grant should expire or funds are dissipated before all outstanding charges have been paid, the Principal Investigators agree that MCV Hospitals/Physicians will bill the covering account identified by the Principal Investigator.

G. Departments Involved In Study (Please mark)

☐ Anesthesiology
☐ Dermatology
☐ Emergency Services
☐ Family Medicine
☐ Human Genetics
☐ Internal Medicine
☐ Neurology
☐ Neurosurgery
☐ Ophthalmology
☐ Orthopaedics
☐ Otolaryngology
☐ Pathology - Lab
☐ Pediatrics
☐ Physical Med & Rehab
☐ OB/GYN
☐ Pyschiatry
☐ Radiation Oncology
☐ Radiology
☐ Surgery

Please list below the requested information covered by the study.

PROCEDURE	CPT CODE	TECHNICAL AMT	PROFESSIONAL AMT

H. Authorization Signature For Each Department That Is Involved In Study

MCV Hospitals	Special Billing Supervisor Title	Date
MCV Physicians	Special Accounts Supervisor Title	Date
Clinical Department/Organization Authorization	Title	Date
Clinical Department/Organization Authorization	Title	Date
Clinical Department/Organization Authorization	Title	Date
Clinical Department/Organization Authorization	Title	Date
Clinical Department/Organization Authorization	Title	Date
Clinical Department/Organization Authorization	Title	Date
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Clinical Department/Organization Authorization	Title	Date
Clinical Department/Organization Authorization	Title	Date

Should you have questions, please contact Alice Fowler, Special Accounts Supervisor, MCV Physicians, at 358-6100 ext 1249 for Physician Billing. For Hospital Billing contact Margaret Johnson, Special Billing Supervisor at 828-2841 ext 1099.

REV. 2-4-11

IRB#	IRB#
STUDY	Study Name
GRANT/ INDEX	Number
RIMARY INVESTIGATOR	PI Name
MONTH	Month/Year

Contact Person: Contact Name/Phone

Subject Name	**MR #**	**Date of Service**	**Exam/Study**	**RECIST/ special**	**In pt/Out pt**	**CPT Code fo SOC**