

5. Provide any financial justification of the product or equipment:

6. CPT code(s) for this item use: _____

7. Is this product an implant? YES NO

8. Is item used as a new tool/supply or for a new procedure not previously performed at UH:
YES NO

9. Is physician credentialed to use this item? YES NO

10. Is this item FDA approved for the application you are requesting? YES NO N/A

11. Planned off-label use? YES NO N/A

If yes, please describe your intended off-label use

12. Have you discussed use of this product with other clinicians who perform this procedure or can you list other surgeons who may use this?

Clinicians/Department Names:

13. Anticipated volume of use (# of patients; procedures/month): _____

14. Does the item require additional components/accessories?

YES NO Explain: _____

15. Can the item be ordered on a case by case basis per OR schedule? YES NO

16. Do you have a conflict of interest with the supplier or vendor (i.e., a financial investment, on the board of directors, receive research support, etc.) YES NO

If yes, then describe the potential conflict

Signatures:

Requestor: _____ Date _____

Clinical Manager/Department Director: _____ Date _____

Value Analysis Facilitator: _____ Date _____

Return form and any pertinent information to Sue Knapp, Value Analysis Coordinator 514C Jacobsen Hall.
Any questions please call 4-4046.