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 | **UNIVERSITY OF MIAMI** **NEW PRODUCTS / EQUIPMENT / SERVICES REQUEST FORM** |
| 1. Incomplete forms will NOT be accepted |
| 2. Deadline for all submissions is 15 days prior to Value Analysis Meeting. The VA team will reach out to you to review prior to meeting. |
| 3. It is the responsibility of the Dept. Dir. or designee to present the product at the Value Analysis Meeting. |
| 4. All requests musts be completed Electronically. **Please email requests to ValueAnalysis@Miami.Edu** |
| 5. **Please send all Vendor documents along with the request.** |
| **This section to be completed by the Requesting Clinician** |
| Request Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date Needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date Started:\_\_\_\_\_\_\_\*\*VA ONLY\*\*\_\_\_\_\_\_ |
| Dept:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Requesting Clinician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Product Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mfr Cat #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Vendor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Procedure Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Estimated Annual Procedure Volume:\_\_\_\_\_\_\_\_\_\_ | Units per Procedure:\_\_\_\_\_\_\_\_\_ | Annual Usage:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Physician Requesting Product:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Physician Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Physicians who will use product:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason for Request: \_\_\_\_Patient Safety\_\_\_\_\_Quality of Care\_\_\_\_\_Improved Technology\_\_\_\_\_Decreased Cost\_\_\_\_\_More Time Efficient |
| Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does the requesting physician have a financial or engaged relationship with the manufacturer/vendor? | \_\_\_\_\_Yes\_\_\_\_\_No |
| Is this product an implant? | \_\_\_\_Yes | \_\_\_\_\_No |   | MSDS required? | \_\_\_\_Yes \_\_\_\_\_No |
| Product is: \_\_\_\_\_\_New \_\_\_\_\_Duplicate \_\_\_\_\_Replacement \_\_\_\_\_Equipment & Disposables \_\_\_\_\_Equipment Only |
| Plans for current inventory Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Additional comments and/or critical information to support request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does the product require additional equipment? | \_\_\_\_Yes | \_\_\_\_\_No |   | Is this item Capital? | \_\_\_\_\_Yes \_\_\_\_\_No |
| Description for Charge Master (24 Character Limit)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please Check One: \_\_\_\_\_\_\_Inpatient Procedure \_\_\_\_\_\_Outpatient Procedure \_\_\_\_\_\_Both |
| Will Procedure impact Labor? | \_\_\_\_ Yes | \_\_\_\_\_# of FTE | \_\_\_\_\_No | Policy? | \_\_\_ Yes | \_\_\_\_\_\_No |
| Will this product/procedure require implementation education? | \_\_\_\_Yes | \_\_\_\_No | If yes, How much?\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Requestor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dept. Dir. Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| AVP Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **This Section to be completed by Material Management** |
| SMART/MSCM#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Is item on contract? \_\_\_\_\_Yes GPO #\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_Local \_\_\_\_\_No |
| Will product be floor stock?  | \_\_\_\_Yes | \_\_\_\_No | If yes, Par Level: \_\_\_\_\_\_Min \_\_\_\_\_\_Max |   |
| Purchase Unit of Measure: | \_\_\_\_\_Cs | (Amt/Cs) | \_\_\_\_\_\_\_ | \_\_\_\_Box | (Amt/Box) | \_\_\_\_\_\_\_ | Each\_\_\_\_\_ |
| Cost Per Unit:\_\_\_\_\_\_\_\_\_\_\_\_\_ | Projected Usage (annual):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Projected Spend (annual):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Consignment Available? | \_\_\_\_Yes | \_\_\_\_\_No |   |   | FDA Approval? | \_\_\_\_\_Yes \_\_\_\_\_No |
| Is there a comparable product on contract?  | \_\_\_\_Yes | \_\_\_\_\_No | Product Info:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is there currently a local agreement in place for this product? | \_\_\_\_Yes | \_\_\_\_No |   |   |
| Has vendor provided Reimbursement/Coding information? | \_\_\_\_Yes | \_\_\_\_No |   |   |
| Is an evaluation needed? | \_\_\_\_Yes | \_\_\_\_\_No |   | Is inservice education needed? | \_\_\_\_\_Yes \_\_\_\_\_No |
| If product conversion, will it result in savings? | \_\_\_\_Yes | \_\_\_\_\_No |   |   |   |
| **This Section to be completed by Finance Department** |
| Item is chargeable (check one) | \_\_\_\_Yes | \_\_\_\_\_No |   | Item is an implant (check one) | \_\_\_\_\_Yes \_\_\_\_\_No |
| CPT Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| APC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   | C Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |
| DRG:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   | Revenue Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |
| Additional Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Approved for Evaluation: | \_\_\_\_Yes | \_\_\_\_\_No |   | Approved for use: | \_\_\_\_\_\_Yes \_\_\_\_\_No |
| CFO Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Revenue Integrity CDM #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |   |   |
| Date Procedure Code entered in SMART/MSCM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |



**NEW PRODUCT REQUEST FORM Conflict of Interest Disclosure:**

**This information is shared with Committee members and is considered when discussing your request. A potential conflict of interest issue does not disqualify someone from requesting the product/technology. The committee recognizes that many departments and members of the Medical/Clinical Staff have relationships with manufacturing companies. Physicians with expertise in this area have often received research grants or other support from companies. However, the committee feels it is important to disclose these relationships.**

**Please identify whether you or your departments directly or indirectly have financial or proprietary interest in the company providing/equipment (monetary payments, royalties, studies, funding, ownership or directorship-if none, please write none)**

**(Signature) (Printed Name)**

**Does the Department (or you) have proprietary interest in the company your request is from? Yes No**

**If yes, which company?**

 **Own Stock in the company (excluding mutual funds)**

**Serve on the board of directors of the company**

**Expect to (or currently receive) royalties from the company**

**Other:**

**Has the Department (or you) received any financial support from the company? Yes No**

**If yes, which company? Receiving funding for research**

**Received support for presenting continuing education or other professional education by the company**

**Received an educational grant**

**Received travel support**

**Other:**