**Research Billing Notification Form**

**Registration Label**

*\*Please submit this form to* *clinicaltrials@iuhealth.org* *at least two weeks prior to the trial start date\**

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| **Account Information** |
| IRB #: |  |
| NCT # (*required*): |  |
| PO #: |  |
| Protocol Title (*12 character limit*): |  |
| Form Completed By:*(name/phone/email):* |  |
| Role | Coordinator [ ]  Investigator [ ]  |
| Financial Manager *(name/phone/email):* | Required for follow up |
| Will this patient have any research supplies, implants, or Investigational Device Exemptions (IDE) associated with this service? | Yes [ ]  No [ ] *\*If yes, please submit the required documentation on Research Billing Packet Page 3* *clinicaltrials@iuhealth.org**.* |
| Is this a grant/research study where the patient will have associated services/charges in which billing and collection efforts are to be fulfilled through IU Health Revenue Cycle Services (RCS)? | Yes [ ]  No [ ] If yes, complete the attached charge form completing all fields.*\*For professional radiology charges, please submit a Research Registration/Grant Charge form (Research Billing Packet Page 2) to* *clinicaltrials@iuhealth.org* *and cc:* *vendacct@iuhealth.org**.*  |
| **Please attach the Monthly Clinical Trials Participant Update form, and send a monthly update of this form highlighting any changes to the document in yellow.** |
| **Signatures** |
| PI Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Coordinator Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Instructions** |
| Should you have any questions about this document please contact clinicaltrials@iuhealth.org **Completed form must be emailed to** clinicaltrials@iuhealth.org*Please include the name of the trial in the subject line* |
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