**Research Registration/Grant Charge Form**

**Registration Label**

**Date of Service: \_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Patient Information** |
| **Patient Name (as it appears in Cerner):** |  |
| **Patient Medical Record Number (MRN):** |  |
| **Patient Date of Birth (DOB):** |  |
| **Sex:**  | [ ]  Male [ ]  Female |
| **Fill in the appropriate areas** |
| **Vendor Name (Study ID):** |  |
| **Billing Account #:** |  |
| **PO #:** |  |
| **Grant Account # (account to be billed):** |  |
| **Administrative Contact:***(name/phone/email)***\*Please note – Bill(s) will be sent to this individual** |  |
|  |
|  | **Detailed Procedure Description** | **IU Health Service Code** | **Profee CPT Code** | **No Radiology Read** | **Service Department/Area Cost Center #** |
|  | *Exam/Consult Room* | *59905687* |  |  |  |
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| **Instructions** |
| **Completed form must be emailed the date service is rendered to** clinicaltrials@iuhealth.org. **If there is a radiology charge, please cc:** vendacct@iuhealth.org.*\*Please enter the name of the clinical trial in the email subject line\** |