**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):** | | |  | | | |
| **IU Health Billing Account #:** | | |  | | | |
| **PO #:** | | |  | | | |
| **NCT#:** | | |  | | | |
| **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](mailto:Clinicaltrials@iuhealth.org). **If there is a radiology charge, please cc:** [vendacct@iuhealth.org](mailto:vendacct@iuhealth.org).  *\*Please enter the name of the clinical trial in the email subject line\** | | | | | | |