**Research Billing Notification Form**

**Registration Label**

*\*Please submit this form to* [*clinicaltrials@iuhealth.org*](mailto:clinicaltrials@iuhealth.org) *at least two weeks prior to the trial start date\**

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| **Account Information** | | |
| IRB #: |  | |
| NCT # (*if applicable*): |  | |
| 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*](mailto: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*](mailto:clinicaltrials@iuhealth.org) *and cc:* [*vendacct@iuhealth.org*](mailto: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.** | | |
| **Instructions** | | |
| Should you have any questions about this document please contact [clinicaltrials@iuhealth.org](mailto:clinicaltrials@iuhealth.org)  **Completed form must be emailed to** [clinicaltrials@iuhealth.org](mailto:clinicaltrials@iuhealth.org)  *Please include the name of the trial in the subject line* | | |
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