

EP 6.17-A

Request for New Clinic Procedures Approval Form

To be completed by requesting physician

Name of requesting physician: _____

Requested Procedure: _____

Department/Clinic: _____

Description: Describe the procedure or treatment, including the indications and contraindications

Equipment: List any new equipment required or indicate "Not Applicable"

Additional Resources: List additional resources required or indicate "Not Applicable"

Staff Training: List any training needed for clinic staff

Date procedure/service is to be implemented: _____

Requestors Signatures:

Physician: _____ Date: _____

Medical Director/Chair: _____ Date: _____

Department Administrator: _____ Date: _____

Approvers Signatures:

Director of Nursing: _____ Date: _____

Office of Claims Management: _____ Date: _____

Office of Medical Staff: _____ Date: _____

Office of Quality Improvement: _____ Date: _____

Coding Department: _____ Date: _____

MPIP Office: _____ Date: _____