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| **INSTRUCTIONS:**   * **Complete this form after each patient visit to report billable procedures /services as outlined on the Financial Clearance approval document for your study.** Type or write legibly * **Submit this form, within 24 hours of the visit,** to the Office of Grant Administration @ [grants@gmh.edu](mailto:grants@gmh.edu) * **Please adhere to HIPAA regulations when submitting this form.** Do not provide patient names or other PHI in subject line or the body of the email.   *Contact OGA at* [*grants@gmh.edu*](mailto:grants@gmh.edu) *with any questions* | | | | | | |
| **The Asterisks (\*) Denotes Required Information** | | | | | | |
| **PI Name: \*** | |  | **Coordinator Name: \*** |  | | |
| **Study IRB#: \*** | |  | **Study Plan Code: \*** |  | | |
| **Name of Patient: \*** | |  | **Visit #:** |  | | |
| **Patient MRN: \*** | |  | **Date of Birth: \*** |  | | |
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| **To facilitate processing, please pay close attention to the following:**   * **Refer to the Financial Clearance approval document** to accurately provide the information requested below. * **Provide one procedure/service per line using the accepted descriptor or abbreviation ONLY.** Refer to the procedures/services on the Financial Clearance Form (FCF). Non-billable procedures/services should not be indicated on this form. * **Indicate agreed upon Standard of Care/Routine procedures by checking the box beside the procedure.** Procedures that were not determined to be billable to Insurance on the FCF will be billed to the Sponsor. * **Provide comments as necessary for visit clarification.** | | | | | | |
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| **Date of Service\*** | **Procedure Descriptor\*** | | | | **Billable to Insurance\*** | **Quantity\*** |
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| **COMMENTS:** | | | | | | |