Physician New Product Request/Evaluation Form

PRODUCT INFORMATION: to be completed by the requesting physician with assistance from manufacturer's rep if needed and submitted to the department director and/or business manager.

Date: _____ Requesting physician/office phone number: _____

Vendor/Distributor: _____ Name of product: _____

Brief Item Description	Catalog #	HCPCS Code	DRG Code	CPT Code	Unit of Measure

COST/UOM	Latex (Y/N)	Implant (Y/N)

Briefly describe this product and clinical impact: _____

List any capital equipment or additional accessories and costs required for the use of product: _____

What improvements to patient care and/or cost reductions are anticipated?: _____

Is a trial of this product requested (Y/N)? _____ If yes, how long? _____

Will product be provided at no charge (Y/N)? _____ If yes, how many units? _____

What procedures will this product be used for? _____

What product that we currently use could this replace: _____

Digital signature (manufacturer's rep): _____

IntelliCentrics/RepTrax Code: _____

Rep email/phone number: _____

Requesting physician signature: _____

Please email this completed form to NewProductRequest@lakehealth.org.

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