NEW MEDICAL TECHNOLOGY REQUEST
APPLICATION FORM

Name of Requesting Physician:_____

Must be completed by Requesting Physician:

Do you or a member of your immediate family have any ownership or investment interest in the manufacturer, distributor and/or seller of the requested New Medical Technology? If yes, please explain:
_____
_____
_____

Do you or a member of your immediate family receive any type of compensation from the manufacturer, distributor and/or seller of the requested New Medical Technology? If yes, please explain:
_____
_____
_____

Do you or will you receive any discounts, business courtesies or free goods or services from the manufacturer, distributor and/or seller of the requested New Medical Technology in consideration of your use and/or promotion of this New Medical Technology? If yes, please explain:
_____
_____
_____

Physician's Signature: _____ Date: _____

Please provide the following information (questions 1 thru 10 should be completed by the physician)

The Medical Staff Department of _____ has endorsed the New Medical Technology. (i.e.: Anesthesia, Cardiology, Urology, etc.)

Medical Staff Department Chairman or Designee Signature _____

Date _____ (Required before submission of application)

1. Describe the requested procedure/technology/therapy. _____
_____
_____
_____

2. What is the current therapeutic modality or similar devices being used at Methodist?
_____
_____

3. Has this technology already been adopted/endorsed by a recognized specialty body (ACC, ASGE, etc)? Please identify. _____

4. Is it proven technology? (Supported by well conducted randomized controlled trials or well conducted cohort studies—provide URL's or attach documentation). _____
_____
_____

5. Please list or attach any related patient selection criteria, including indications for use ("IFU's"),if applicable._____
_____
_____

6. How is this procedure/technology/therapy different/more effective than the current modality?
_____
_____
_____

7. What are the relative risks/benefits of the new procedure/technology/therapy? _____
_____
_____
_____

8. What are the expected outcomes? (Delineate all clinical quality indicators to include in metrics)
_____
_____

9. What continuing medical education courses will this procedure/technology/therapy require prior to its use? Describe the training required by the physician in order to use the new technology. _____
_____
_____
_____

10. Please outline and attach the qualifications/privileges criteria for safe use of the procedure/technology/ therapy. _____

(Questions 11 through 18 should be completed by the clinical director):

Name of Department Director: _____

Signature: _____ Date: _____

Facility: _____

11. What specialized departmental training (including nursing staff and other clinicians) will be required to use this technology? Who will do the training?
_____
_____

12. Projected monthly utilization across the System. _____

13. Other resources required (e.g. radiology, surgical backup, ICU bed requirement, respiratory therapy, etc.) _____

14. Nature of the technology:

_____ **Same or Similar Technology**.
_____ **Replacement Technology**

If so identify the technology by providing:
_____ Product/Device
_____ Manufacturer
_____ Catalog Number
_____ SAP # (If available)
_____ Procedure Code/Charge Master Code

_____ **New Technology**

Please provide for technology being considered:
_____ Product/Device
_____ Manufacturer
_____ Catalog Number
_____ Cost of Product/Device

15. Date of FDA Approval _____ (Attach copy of Approval Letter)
If "Substantially Similar Device" check box and attach copy of FDA 510K Approval Letter [ ]

16. Specify the **new/additional** procedures/services that will be utilized in connection with this technology.

Inpatient~

Proc Code /DRG	Description	Est Volume per Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

Outpatient~

Proc Code/CPT	Description	Est Volume per Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

17. Specify the estimate of LOS.

_____ LOS for Same/Similar/Replaced Existing Technology.
_____ LOS for Proposed Technology

18. If the new procedure/technology/therapy requires a capital expenditure, a financial review will need to be performed. This review should be coordinated through your Hospital's Chief Financial Officer prior to submission of this request. Thus the capital for the new procedure/technology/therapy would be approved and funding committed for this capital prior to submission for New Medical Technology review. Please anticipate the time frame of 60 to 90 days for the completion of the review.