INSTRUCTIONS

OFFICE OF LOGISTICS MANAGEMENT (OLM)

Request for Implant, Instrument or Supply for Procedure Form – LM-12

Reference #:

You must complete this Form On-Line. Hand written Forms will be rejected. Mail, Fax or PDF the entire package to:

Submit Form To:	**Dan Hannon, Resource Manager** Purchasing Services Room #: FB054 MC 2012 Telephone: 679-2740 Fax: 679-1993

SECTION 1: (To be completed by physician/physician's designee)

Physician:		Procedure Date:	
Prepared by:		Date:	
Department Head:		Phone Number:	
Department:		Division:	
Phone Number:		Fax Number:	
Room Number:		Mail Code:	
Email Address:			
Procedure: CPT/HCPCS Codes:			
One-Time Use Only:	Yes ☐ No ☐	Notes:	
Patient Name:		Medical Record Number:	
Name of Insurance Company/Payer:			

Description of Procudure:

Inpatient procedure, expected length of stay: Number of Days:	Check One:	Outpatient ☐ Inpatient ☐

Requested Implant/Instrument/Supply Description:

Requested Implant/Instrument/Supply CPT/HCPCS Codes:

Has Implant/Instrument/Supply received FDA approval?: Yes ☐ No ☐

Description & justification of supplies/equipment/drugs needed for device:

Vendor:		Product #:	
Vendor Rep's Name:		Phone #:	

1. Physician Signature Typed Name - Mandatory	Date:	
2. Department Head Typed Name - Mandatory	Date:	

SECTION 2 (To be ccompleted by Resource Management):			
On Contract?:	Yes ☐ No ☐	If "Yes", Contract #:	
Product Cost:		Shipping Cost:	
Date Prepared:		Associated supplies/equipment/drug cost:	
1. Authorized Resource Management Signature Typed Name - Mandatory		Date:	

SECTION 3 (To be ccompleted by the procedure Services Department Head or Designee):		
Date Prepared:		Notes:
Expected Billed Charges on Implants & Peripherals:		
Expected Billed Charges for Impatient Stay/Out Patient Visit:		
Projected Cost of Inpatient Stay/Outpatient Visit:		
1. Department Head/Designee Signature Typed Name - Mandatory	Date:	

SECTION 4 (Reimbursement Department)		
Date Prepared:		Notes:
Expected reimbursement for procedure:		
Projected cost of inpatinet Stay/Outpatient Visit:		
Expected Income (Loss):		
Notes:		

Approvals:
If inpatient stay/outpatient procedure is expected to generate income, Reimbusement approval is needed. If inpatient stay/outpatient procedure is expected to generate a loss, approval of the Reimbusement and Procedure Service Department Head is required. The approvals must be obtained prior to acquiring the prosthesis/implantable.

Signature	Date:	
1. Reimbursement Representative Signature Typed Name - Mandatory	Date:	
2. Procedure Service Department Head Signature Typed Name – Mandatory	Date:	

"See Attachment A"