JOHNS HOPKINS HOSPITAL

RADIOLOGY RESEARCH POLICY DOCUMENT

RESEARCH STUDIES OR SPECIAL CARE PROGRAMS
THIRD PARTY BILLING FOR SERVICES RENDERED FOR RADIOLOGY SERVICES
For Questions email: Lori Deluca lpolloc1@jhmi.edu

UPON COMPLETION, PLEASE FAX THIS SHEET TO ABOVE NUMBER

Date: _____

Name of Investigator controlling funds: _____

Office location: _____ Telephone number: _____

Name and Address of Person bills are to be sent: _____

_____

Phone number: _____

Name of Study Program: _____

Date of initiation of grant: _____ Date of termination of grant: _____

RPN: _____ Proposed number of patients: _____

Means of identifying patients/subjects: _____

Total grant funds available for service to patients: _____

REQUIRED INFORMATION FOR RADIOLOGY IMAGING SERVICES: Please answer the following questions to ensure correct radiology services and billing are provided for your study.

1. Indicate below the Radiology Imaging Services required for your study patietns:

☐ Diagnostic ☐ Mammography ☐ Pediatrics ☐ Body CT ☐ Head CT

☐ Neuro Radiology ☐ Nuclear Medicine ☐ PET ☐ Ultrasound ☐ MRI

☐ Interventional Radiology

2. ☐ Outpatient ☐ Inpatient ☐ Both

3. Routine Radiology Imaging Services include two separate charges: hospital charge and professional fee. Are there any requirements that professional fees be excluded? If yes, indicate below the requirements.

☐ Yes ☐ No **If you answered Yes, please indicate why:**

_____

_____ _____

Signature of Investigator Controlling Funds Date

_____ _____

Received by Radiology Business Office Date