



REVIEW OF NEW MEDICAL TECHNOLOGY FORM

Member Name: _____ **Date:** _____

Member ID# _____ **DOB** _____

Review Type **Reactive** **Proactive**

Requesting Practitioner: _____ **Phone #** _____

Proposed Treating Practitioner: _____

Proposed Procedure / Treatment / Medication: _____

Facility: _____ **Phone #** _____

Professional Cost: _____

Anticipated LOS: _____ **Facility Cost:** _____

1. **How long has treating practitioner been performing this procedure or treatment?**

2. **How many cases has he/she performed in the last two years?**

3. **Estimated Costs:**

| | |
|------------------------------|----------|
| Professional | \$ _____ |
| Facility | \$ _____ |
| Other | \$ _____ |
| Total Estimated Cost: | \$ _____ |

4. **Is privileging or certification required to perform this procedure?**
 Yes **No**

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5. Outcomes Review:

- Mortality during global period? _____
- Mortality during 1 year out? _____
- Mortality during 5 years out? _____
- Other known complications / risks, actual and anticipated?

6. List other available treatment modalities:

7. Medicare approved? _____

8. FDA approved? _____

9. Hayes Directory review? _____

10. Literature Search? _____

11. Review by Network Practitioners:

Name

Specialty

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |



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12. **Medical Director Review:** _____

13. **Other comments:** _____

14. **Send for External Review?** Yes _____ No _____

15. **Cover?** Yes _____ No _____

16. **Notify Benefits Coordination?** Yes _____ No _____

17. **Date Member notification sent** _____

18. **Date Provider notification sent** _____

Partnership Medical Director

Date