

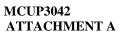
## **REVIEW OF NEW MEDICAL TECHNOLOGY FORM**

Men	nber Name:			Date:
Men	nber ID#			DOB
Revi	iew Type	Reactiv	v <b>e</b>	☐ Proactive
_	uesting ctitioner:			Phone #
Prop	posed Treatii	ng Practitio	ner:	
Prop	posed Proced	ure / Treati	ment / Medication: _	
 Faci	ility:			Phone #
Prof	fessional Cos	t:		
Anti	icipated LOS	:		Facility Cost:
1.	How long l treatment?	_	practitioner been po	erforming this procedure or
2.	How many	cases has h	ne/she performed in t	the last two years?
3.	Estimated	Costs:		
			Professional	• ————————
			Facility	\$
			Other Total Estimated C	\$ !ost: \$
4.	Is privilegi	ng or certif	ication required to p	erform this procedure?



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utcomes Review:					
<ul> <li>Mortality during global period?</li> <li>Mortality during 1 year out?</li> </ul>					
Other known complications / ri	sks, actual and anticipated?				
st other available treatment mo	dalities:				
edicare approved?					
ayes Directory review?					
terature Search?					
eview by Network Practitioners:					
<u>ame</u>	<b>Specialty</b>				
	<del></del>				





## **REVIEW OF NEW MEDICAL TECHNOLOGY FORM**

Other comments:		
Send for External Review?	Yes	No_
Cover?	Yes	No_
Notify Benefits Coordination?	Yes	No_
Date Member notification sent		
Date Provider notification sent		