# 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 _____**

_____ _____

**PHC Medical Director** **Date**