**Clinical Trial Insurance Predetermination Form**

**Step 1: Insurance Verification/Exclusion Clause -** *(Study Coordinator to Complete)*

**Name of Trial:** Click here to enter text.

**Study Coordinator Name**: Click here to enter text. **Phone #:** Click here to enter text. **Date of Request:** Click here to enter a date.

Patient Name: Click here to enter text. Patient MRN: Click here to enter text. Patient DOB: Click here to enter text.

Gender: Click here to enter text. Age: Click here to enter text. Patient Diagnosis Code: Click here to enter text.

Consent Obtained? ☐ YES **☐** NO Date of Consent if Obtained: Click here to enter a date.

☐ Urgent (within 1 week) Expected Start Date of Treatment: Click here to enter a date.

Estimated Length of Time on Treatment: Click here to enter text. Phase of Trial: Click here to enter text.

Sponsor/funding of clinical trial (payment source):

☐ Federal ☐ Non-Governmental research issued by NIH ☐ VA/DOD/DOE ☐ Industry sponsor

☐ IND exempt ☐ Conducted under an IND ☐ Device trial ☐ Radiation therapy trial

ClinicalTrials.Gov Study #: NCTClick here to enter text.

Additional Information for Finance Counselor: Click here to enter text.

Include the following:1.Request Form 2. Study Synopsis 3. Matrix

**EMAIL this form with attachments to:** [PASFinancialCounselor@nebraskamed.com](mailto:PASFinancialCounselor@nebraskamed.com) **Phone**: 559-5346

*(Financial Counselor to Complete)*

**Financial Counselor Name:** Click here to enter text. **Date Information Sent Back to Coordinator:** Click here to enter a date.

Patient’s Primary Insurance: Click here to enter text. Patient’s Secondary Insurance: Click here to enter text.

Does this Patient have a Trial Exclusion Clause? **☐** YES  **☐** NO

Is it OK to move ahead and consent this patient? **☐** YES **☐** NO

Comments: Click here to enter text.

**Step 2 Predetermination Request -** *(Financial Counselor to Complete)*

\*\* **Some Insurance Companies may indicate that no predetermination is required, however we will need a predetermination number or at least a promise of a predetermination number (sometimes it takes up to 30 days to process the request) to enroll and start a patient on study.**

Primary Contact Person at Patient’s Insurance Company: Click here to enter text.

Date of First Request to Insurance Company: Click here to enter a date.

Predetermination #: Click here to enter text. Date Provided: Click here to enter a date.

Comments: Click here to enter text.